2016

State of Montana
Employee Group Benefits Claim Audits

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
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LEGISLATIVE AUDIT DIVISION

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August 2016

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the state of Montana employee benefit claim audit plans for the two calendar years ended December 31, 2015 including:

- Cigna - Medical
- Delta Dental - Dental
- MedImpact - Pharmacy

The audit was conducted by Claim Technologies Incorporated under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of the audit report.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

15C-09

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY

State of Montana Medical Plans
Administered by Cigna

Audit Period: January 1, 2014 through December 31, 2015

Presented to

State of Montana

July 13, 2016

Presented by

CLAIM TECHNOLOGIES INCORPORATED

Known in Montana as CTI Claim Audit Technologies Corp.

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INTRODUCTION

This ***Executive Summary*** contains findings and recommendations from CTI's comprehensive audit of Cigna's claim administration of the State of Montana (the State) plans. Supporting detail for these findings and recommendations are in the ***Specific Findings Report***.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Cigna and CTI in their efforts to serve the interests of the plan participants of the State of Montana Medical Plans. All findings are based on the data and information provided to CTI by Cigna and the State. Therefore, the validity of the findings relies heavily upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between Cigna and the State as well as the approved benefit descriptions (summary plan descriptions, plan documents or other communications).

CTI is a firm specializing in independent audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the administrator's policies, processes and systems as they apply to the State's paid claims during the audit period.

OBJECTIVES AND SCOPE

Audit Objectives

The specific objectives of CTI's comprehensive audit of Cigna's claim administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for the administrative services between the plan sponsor and claim administrator were followed;
- Determine whether claims were paid according to the provisions of the summary plan description (SPD) and the terms of the SPD were clear and consistent;
- Determine whether members were eligible and covered by the sponsor's medical plans at the time a service paid by Cigna was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a comprehensive audit of Cigna's claim administration of the State's medical plans for the 14-month period of January 1, 2015 through February 29, 2016. The population of claims and amount paid by the plans during the audit period were:

Total Paid Amount	$131,865,937
Total Number of Claims Paid/Denied/Adjusted	426,404

The audit included the following components which when viewed together provided evidence that allowed us to produce this report.

- Random Sample Audit of 180 claims
- 100% Electronic Screening With 30 Targeted Samples (ESAS®)
- Plan Documentation Review
- Operational Review
- Data Analytics

CTI's findings in each of the audit components and our recommendations follow.

KEY FINDINGS

Random Sample Audit

Methodology

CTI validated the accuracy of claims processing based on a sample of 180 medical claims paid or denied by Cigna during the audit period. We selected the random sample (stratified by the claim billed amount and the date processed) to provide a statistical confidence level of 95% +/- 3% margin of error. Our audit system classified errors identified through the sample by type and frequency. CTI then requested input and additional documentation from Cigna about the potential errors. CTI's initial determination of an error was provided to the administrator in a working draft report. The administrator was given the opportunity to provide additional information in its response to the working draft. This additional response was considered when compiling our reports.

Findings

CTI's random sample audit system categorizes errors into Key Performance Indicators. This systematic labeling of errors and calculation of performance is the basis for CTI's benchmarks that are generated using the most recent 100 medical claim administration audits completed by CTI.

The following table demonstrates that Cigna's performance was below the median average in CTI's benchmarked Key Performance Indicators. For more specific information on our benchmarks and how the administrator performed in this audit, see the box and whiskers charts in Exhibit A.

Key Performance Indicators	Administrator's Performance by Quartile			
	Quartile 1	Quartile 2	Quartile 3	Quartile 4
Financial Accuracy Rate	◔			
Accurate Payment Frequency	◔			
Accurate Processing Frequency	◔			
Adjudication Proficiency		◑		
Documentation Accuracy – Financial				●
Documentation Accuracy – Frequency				●

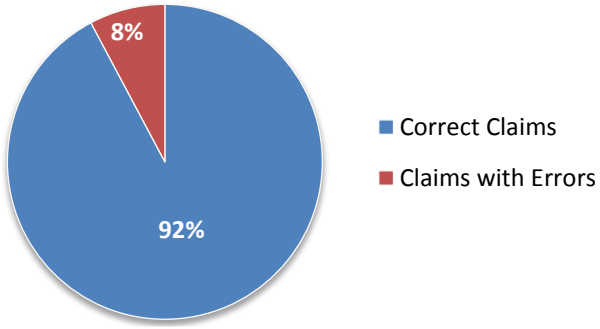
Key	Quartile 1	Quartile 2	Quartile 3	Quartile 4
	◔	◑	◕	●
	Lowest Performance →			*Highest Performance*

The definition for each Key Performance Indicator is in Exhibit B.

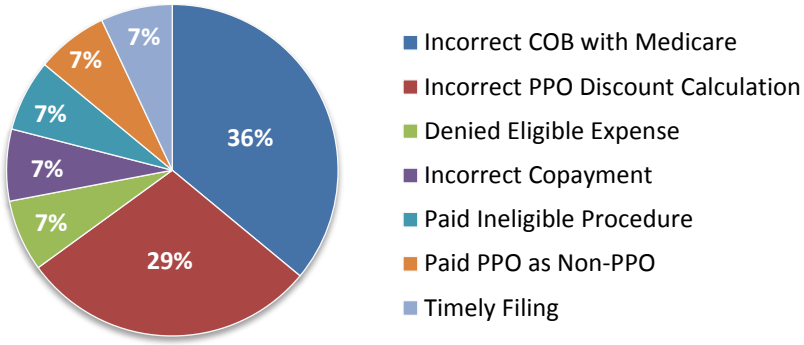
Prioritization of Process Improvement Opportunities

The following charts will help to prioritize improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes. The recommendations section of this report provides next steps to achieve improvement and discussion.

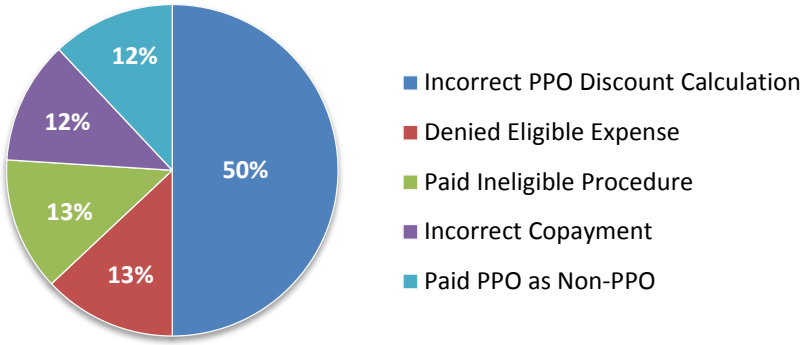
Overall Accurate Processing Frequency



Financial Accuracy by Error Type



Accurate Processing Frequency by Error Type

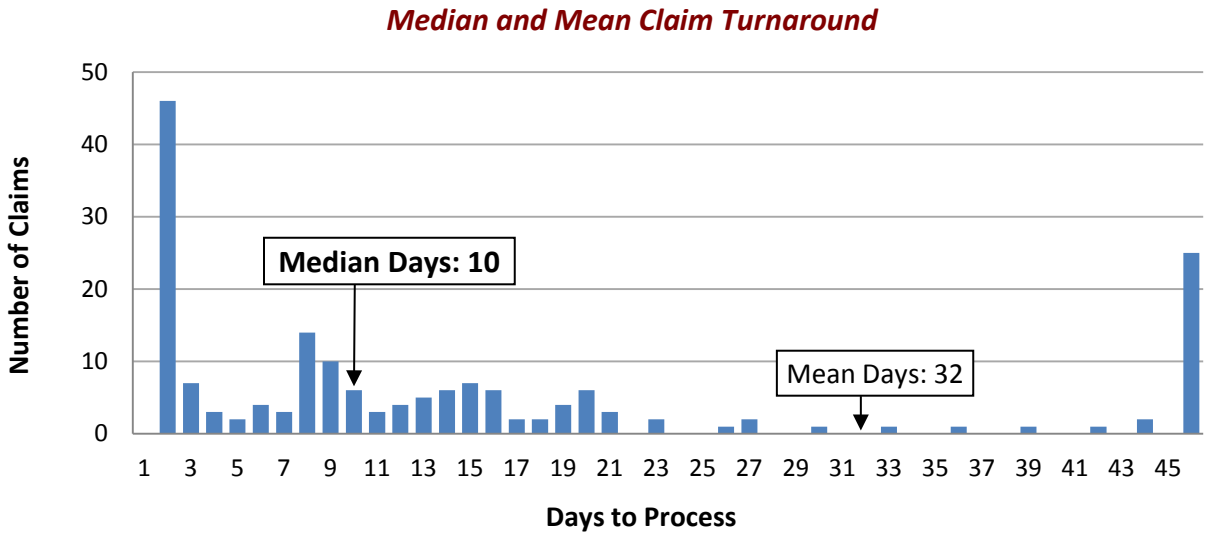


Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Cigna demonstrated that its median turnaround time on a complete claim submission was 10 days from the date it received a complete claim to the date it was paid or denied. It should be noted that 25 claims of the 180 claims in the sample took greater than 45 days to pay.

A median claim turnaround time in this range allows the plan to maximize provider discount savings and reduce the number of resubmissions while still allowing reasonable time for

investigation and review of claims to determine payment. In our experience, many provider discount agreements require complete claims to be processed within a certain timeframe – with 15 or 30 days being most common. CTI does not have a benchmark for this measure; instead, we illustrate the distribution of turnaround time for claims in the following chart.



100% Electronic Screening with Targeted Samples (ESAS®)

Scope and Methodology

CTI employed our proprietary ESAS software to further analyze claim payment accuracy and opportunities for system and process improvement. We screened 100% of claims paid or denied during the audit period and auditors selected a targeted sample of 30 electronically screened claims to validate findings and test Cigna's claim administration systems. The administrator reviewed and responded to potential recovery and improvement opportunities we cited in a working draft report. This additional information was also taken into consideration when finalizing our reports.

Findings

The following table shows the number and dollar value of medical services identified as potentially overpaid. It is important to note that the amounts shown represent potential payment errors. Additional testing would be required to substantiate the findings and to provide the basis for remedial action planning or recovery.

For more specific information on the over- and under-payments that were identified, see the ESAS section of the ***Specific Findings Report***.

ESAS® Candidates for Additional Testing	Potential Recovery/Savings
Excluded services: • Orthotics • Impotency • Abortions, Elective	$59,862
Plan limitations: • Timely Filing of Claims • TMJ Non-Surgical Not Covered	$176,867

Operational Review

Scope and Methodology

Cigna completed our operational review questionnaire that provided information on their:

- Systems, staffing and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms e.g., HIPAA protections; internal audit policies and practices; and fraud, waste and abuse detection and prevention.

Findings

Our operational review found:

- Cigna provided a copy of its self-reported performance against contractual guarantees for calendar year 2015. Cigna did not attain the required goal for timeliness of medical claims processing, which is 96% within 14 calendar days. The penalty associated with this performance guarantee is $.32 per employee per month. The State should ensure that Cigna has paid this amount due. In addition, CTI notes that the contractual guarantee for financial accuracy of medical claims processing is measured at the "office" level (meaning for all claims processed at the same service center that handles the State's claims). CTI's independent audit of Cigna's performance indicates that financial accuracy for the State's claims alone was not met. Cigna's contract with the State also includes performance guarantees for provider rates. CTI's independent validation of discounts showed that Cigna's discount rates exceeded the guarantee of 20%.
- Cigna furnished an overpayment recovery report for the period January 2015 through February 2016. The State should ensure that it continue to monitor overpayment recovery until all open claims have been recovered or closed.
- Cigna furnished appeals reports for calendar year 2015 and for the period January 1, 2016 through May 31, 2016. Of 210 appeals (both administrative and medical) filed in 2015, only 19% were overturned. CTI notes, however, that Level 1 medical appeals constitute 36.7% of total appeals volume. This is the second highest type of appeal, after Level 1 administrative appeals. Thirty-one of 77 appeals were overturned when providers not associated with the original case reviewed records on appeal. Similarly, in 2016, 23.2% of all appeals were overturned. However, 12 of 28 Level 1 administrative appeals included in the 2016 report or 42.9% of the 28 appeals filed, were overturned on appeal. The State should ask Cigna what led to the high percentage of appeals where original medical decisions were overturned and how this information is relayed to staff making the original coverage decision.
- Cigna has a central unit for investigation of potential fraud in its office in Bloomfield, CT. Cigna recognizes that health care fraud impacts both the cost and quality of medical coverage by increasing the cost of doing business and creating a loss of public confidence. CTI observes that the fraud reporting provided by Cigna is better than we see from other administrators and that Cigna denied $232,579 in fraudulent claims during calendar year 2015 in the categories of misrepresentation of services, not medically necessary services, fee forgiveness and unnecessary services.

Plan Documentation Review

Scope and Methodology

CTI evaluated the summary plan descriptions (SPD), plan documents, member handbooks and contracts between the State and Cigna for clarity and consistency. We then created a benefit matrix to identify inconsistencies and/or missing provisions that needed to be clairifed with the State. Once clarified, our auditors used the benefit matrix as a cross reference tool as they audited claims.

Findings

Our plan documentation review indicated the State's summary plan description:

- After review of the plan documents, and as observed through the course of ESAS (see CTI QID #9), plan document language on the exclusion of hearing aids found on pages 58 and 77, item 12 of the 2013 SPD should be reviewed to specifically state which parts of hearings aids are not covered. Cigna paid the related ear mold/insert as plan language does not specifically state it is not covered. Current plan language states: "vision examinations (may be covered under a separate vision exam plan described in II.D.1), orthoptics, vision training, hearing examinations, corrective appliances, and laser eye surgery. Corrective appliances include glasses, contact lenses, and hearing aids."

Data Analytics

The data analytics conducted by CTI included:

- Network Provider Utilization and Discount Savings
- Affordable Care Act Preventive Services Coverage Compliance
- National Correct Claim Coding Initiative Editing Capability

Network Provider Utilization and Discount Savings

CTI compared submitted charges to allowable charges for all claims paid during the audit period for the plans. The analysis relied on the data provided by the administrator and no assumptions were made when necessary data fields were not provided. The following table shows the results of CTI's analysis of the value of discounts given by network providers as a percentage of all claims processed during the audit period.

Total of All Claims				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$9,637,475	$2,606,289	27.0%	$5,666,814
Non-Facility	$74,364,559	$21,421,324	28.8%	$40,085,090
Facility Inpatient	$54,004,213	$9,903,579	18.3%	$41,238,002
Facility Outpatient	$65,775,077	$11,684,412	17.8%	$44,876,031
Total	**$203,781,325**	**$45,615,603**	**22.4%**	**$131,865,937**

Utilization of network providers by the State members was high at 96.4% of all allowed charges and 95.0% of all claims. The average discount-off allowed charges from network providers exceed the contractual guarantee of 20%.

Affordable Care Act Preventive Services Coverage Compliance

CTI's preventive care services compliance analysis was used to confirm that the claim administrator was processing preventive services as required by the Patient Protection and Affordable Care Act

(PPACA) and as regulated by the Department of Health and Human Services (HHS). The federal mandate under PPACA for all health plans (unless the plan is grandfathered as defined under PPACA) is that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance or deductible. The review analyzes in-network preventive care services to determine whether or not those services have been paid in compliance with the PPACA guidelines.

CTI's analysis found that 93.53% of the procedure codes identified as preventive services were paid by Cigna at 100% when provided in-network. A detailed list of the other 6.47% is in the data analytics section of the ***Specific Findings Report.***

National Correct Coding Initiative Editing Capability

CTI analyzed Cigna's claim system code editing capability to determine the degree to which it conformed to National Correct Coding Initiative (NCCI) guidelines used by the Centers for Medicare & Medicaid Services (CMS) for Medicare Part B and Medicaid claims. Although these edits are not mandatory for non-Medicare/Medicaid medical plans, it is important that the State understand the benefit of these initiatives and their potential value when applied to medical benefit plans. CTI believes the two CMS initiatives that can offer the greatest return benefit to self-funded employee benefit plans are:

- Procedure to Procedure Edits, and
- Medically Unlikely Edits.

Our claim system code editing analysis identified medical services that were submitted to the plan and paid by Cigna that would have been denied by Medicare and Medicaid using the NCCI guidelines. In order for Medicare or Medicaid to reconsider these charges, the provider would have been required to resubmit with correct coding. Since Cigna paid the billed charges, the payments represent a potential savings opportunity to the State. Below are our findings by CMS initiative:

Claim System Code Editing Capability Analysis by CMS NCCI Initiative		
	Procedure-to-Procedure Edits	**Medically Unlikely Edits**
Facility	$0	$0
Non-Facility	$885,455	$110,000
Ancillary	N/A	$606

For each CMS NCCI initiative, a complete listing of edited medical services by procedure code is provided in the data analytics section of the ***Specific Findings Report.***

RECOMMENDATIONS

CTI recognizes that the State has terminated its contract with Cigna. As a result, our recommendations focus on the potential for overpayment recovery and continued monitoring of performance during the run-out period. Based on the findings of our comprehensive audit of Cigna, we make the following recommendations to the State:

1. Review Cigna's response to the audit report to determine whether remediation of claims paid in error has been completed. The State should request a final report from Cigna once all remediation is completed. For issue identified by ESAS, claim detail can be prepared by CTI for Cigna to use in their analysis.
2. Meet with Cigna to discuss the audit findings. To facilitate this discussion, you should request that Cigna review each of the financial errors identified by our random sample audit. The discussion should focus on the two issues that were identified most frequently:
    a. Correct administration of PPO discounts
    b. Correct coordination of benefits with Medicare
3. Use the information provided as part of the data analytics component of the audit to discuss findings with Cigna. While Cigna does have code editing in place, CTI recommends having discussions with Cigna to understand why not all of the NCCI edits have been incorporated into the claims processing system. CTI found $996,061 in Procedure-to-Procedure and Medically Unlikely edits that were paid by Cigna.

We understand that you will need to review these recommendations to determine the subject of immediate action. Should the State decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers 10 hours of post-audit time to provide you with further assistance.

Cigna cooperated with this audit and made every effort to provide us with the data and documentation we requested.

We have considered it a privilege to have worked for, and with, your staff and would welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

EXHIBITS

A. Performance Measurements and Benchmarking

B. Key Performance Indicators

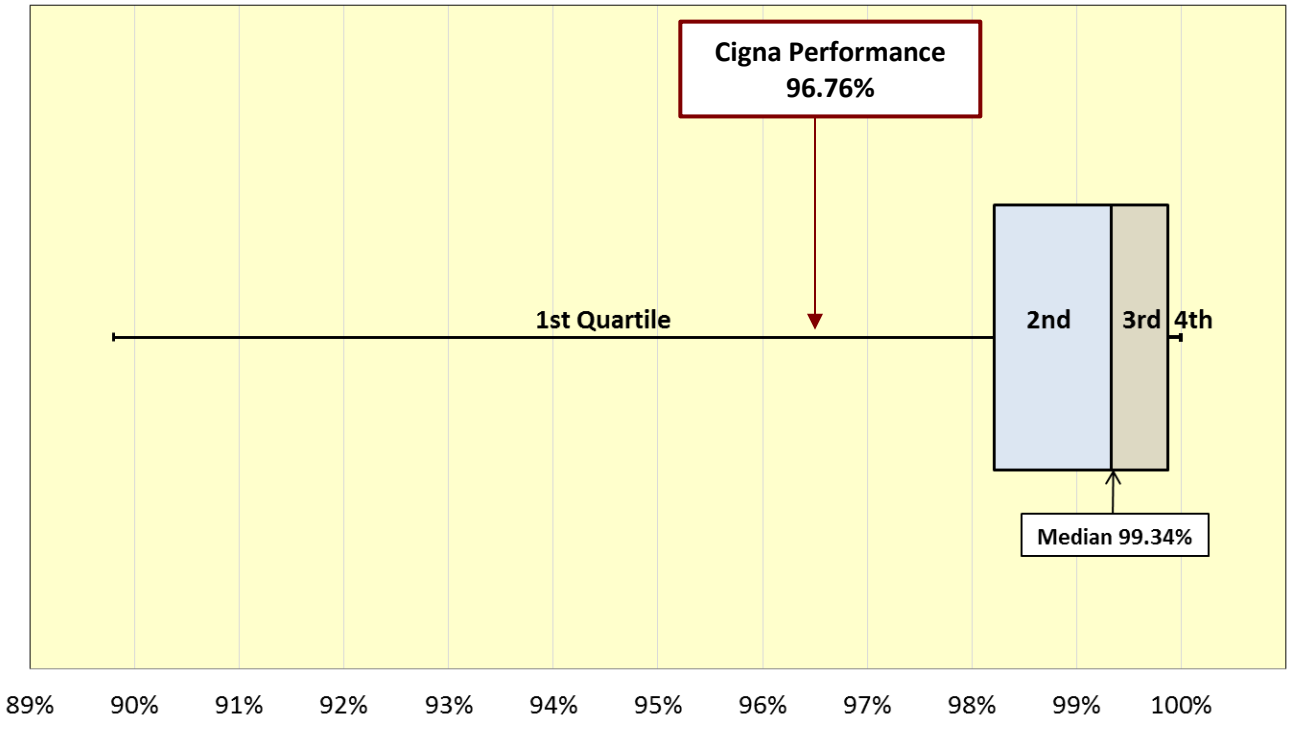
EXHIBIT A – Medical Performance Measurement

The following box and whisker charts are based on the 100 most recent medical claim administration audits performed by CTI. The charts are used to demonstrate the administrative performance when compared to the other plans against each of our Key Performance Indicators.

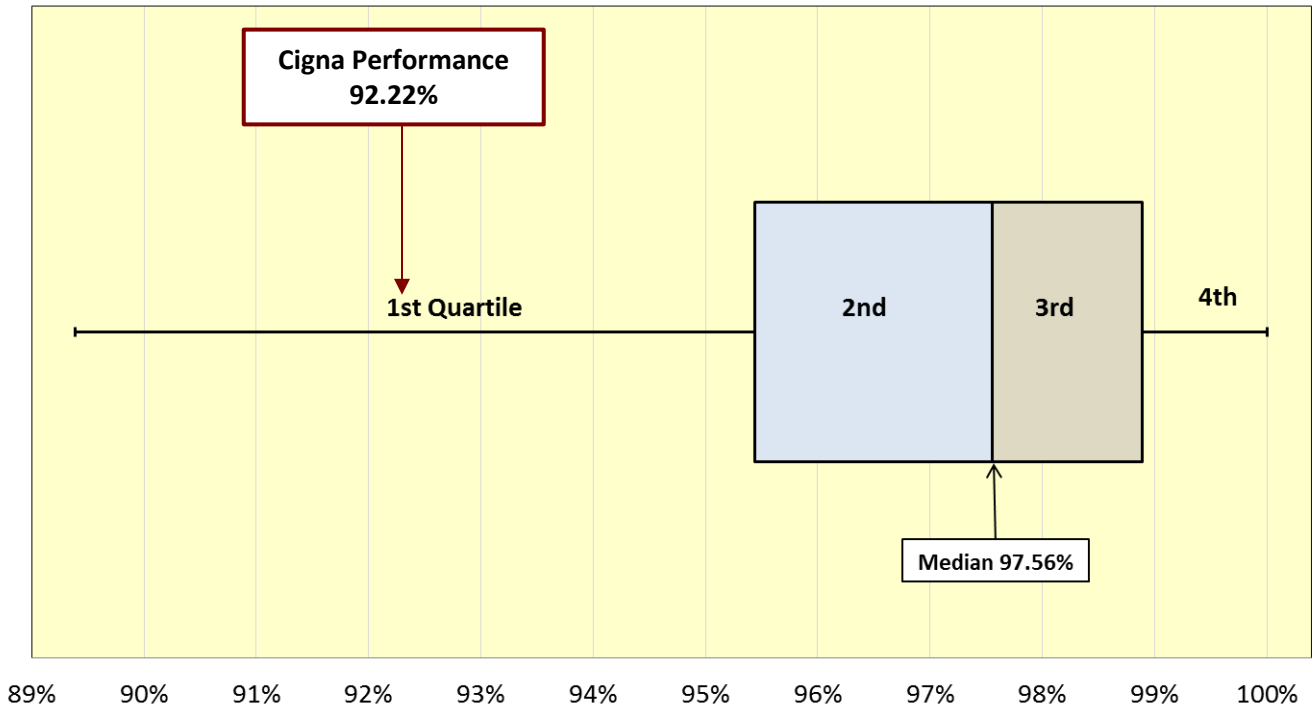
Each chart contains the following information:

- Cigna performance
- Benchmark performance
- Lowest performance
- Performance levels by quartile – with the 4th quartile representing the highest 25 performing plans and the 1st quartile representing the lowest 25 plans
- Performance level relative to the Median – or the level at which 50 of the plans audited were higher and 50 were reported to be lower

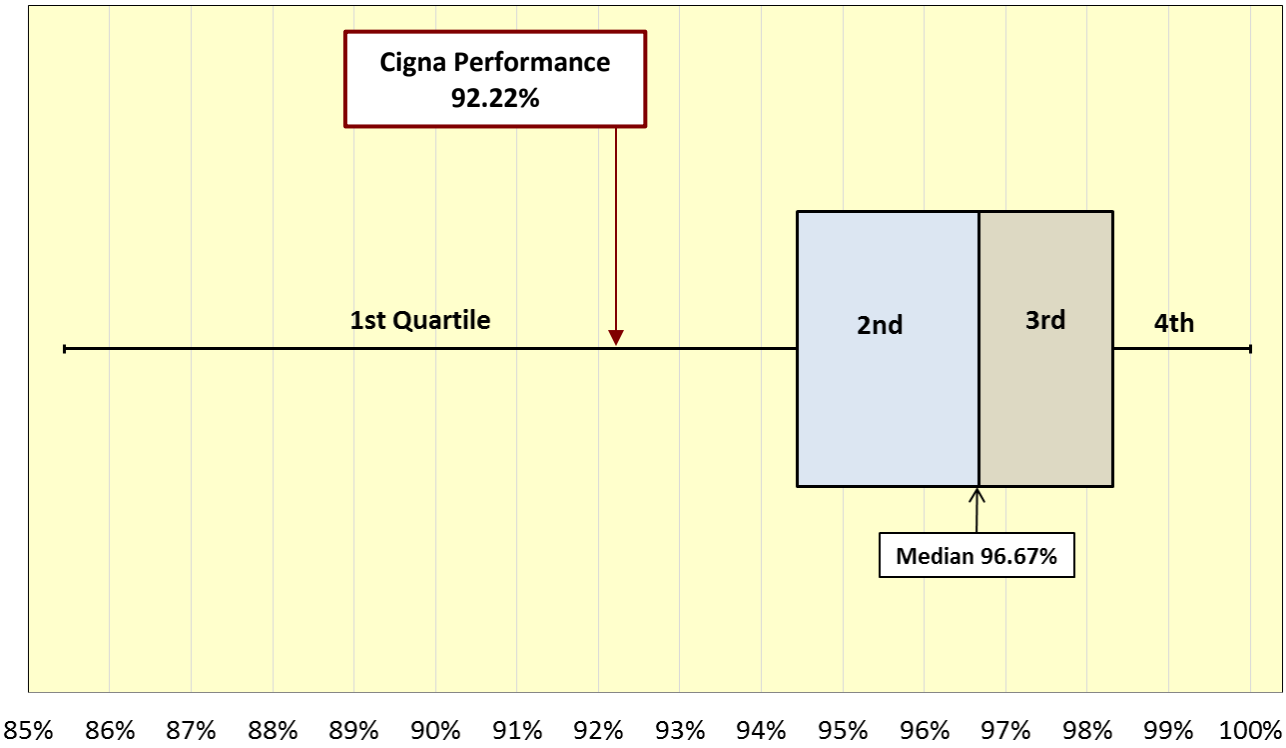
Financial Accuracy Rate – Performance vs. Other CTI Plans Audited by Quartile



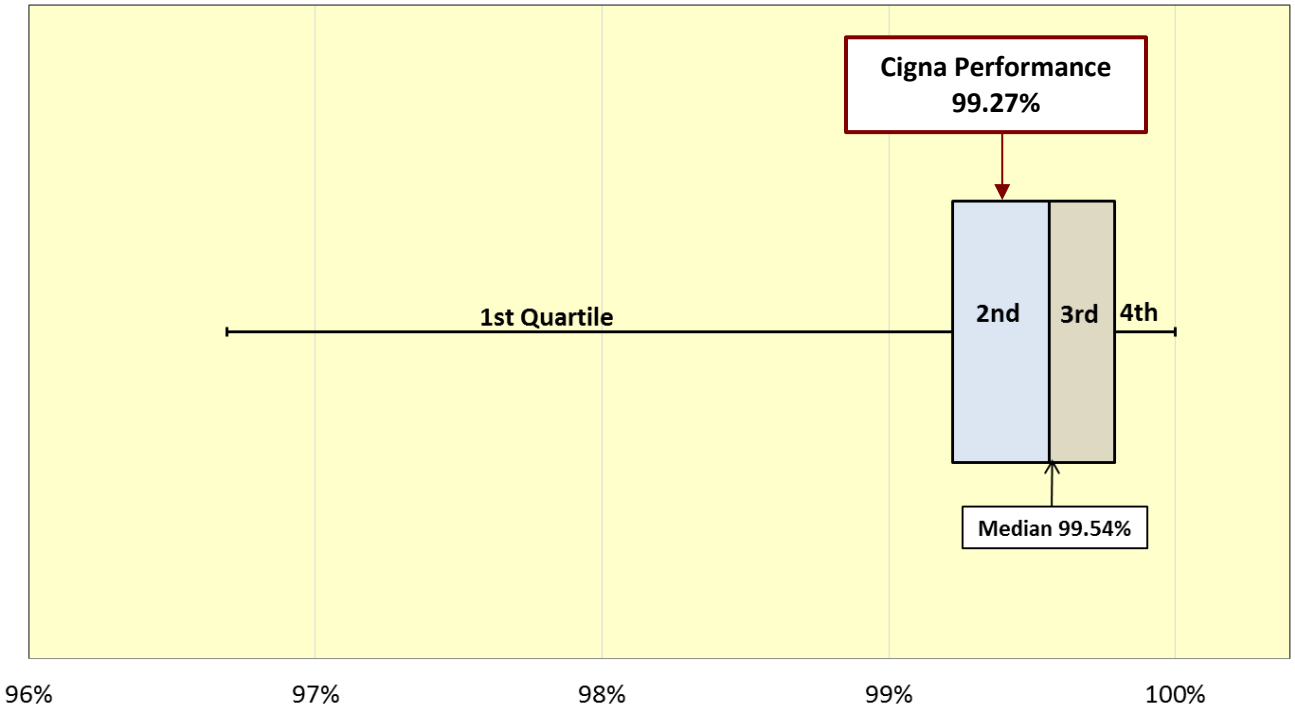
Accurate Payment Frequency – Performance vs. Other CTI Plans Audited



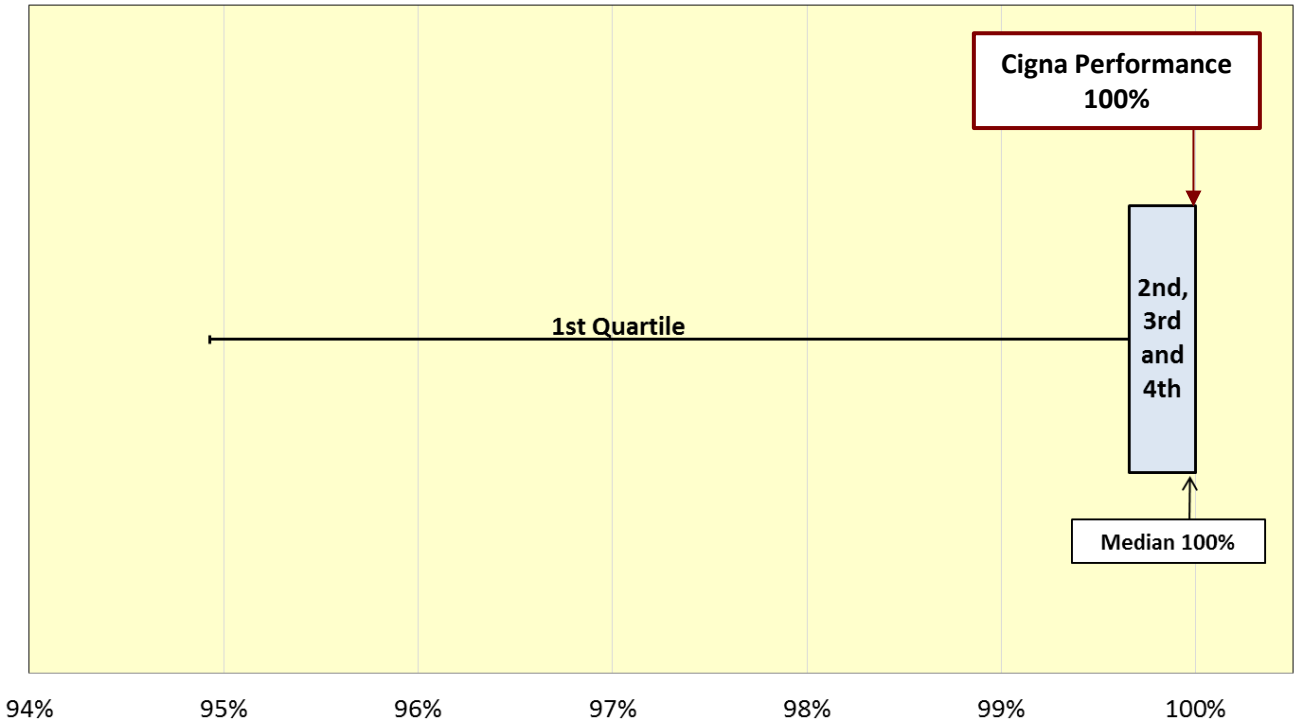
Accurate Processing Frequency – Performance vs. Other CTI Plans Audited



Adjudication Proficiency – Performance vs. Other CTI Plans Audited



Documentation Accuracy Financial – Performance vs. Other CTI Plans Audited



Documentation Accuracy Frequency – Performance vs. Other CTI Plans Audited

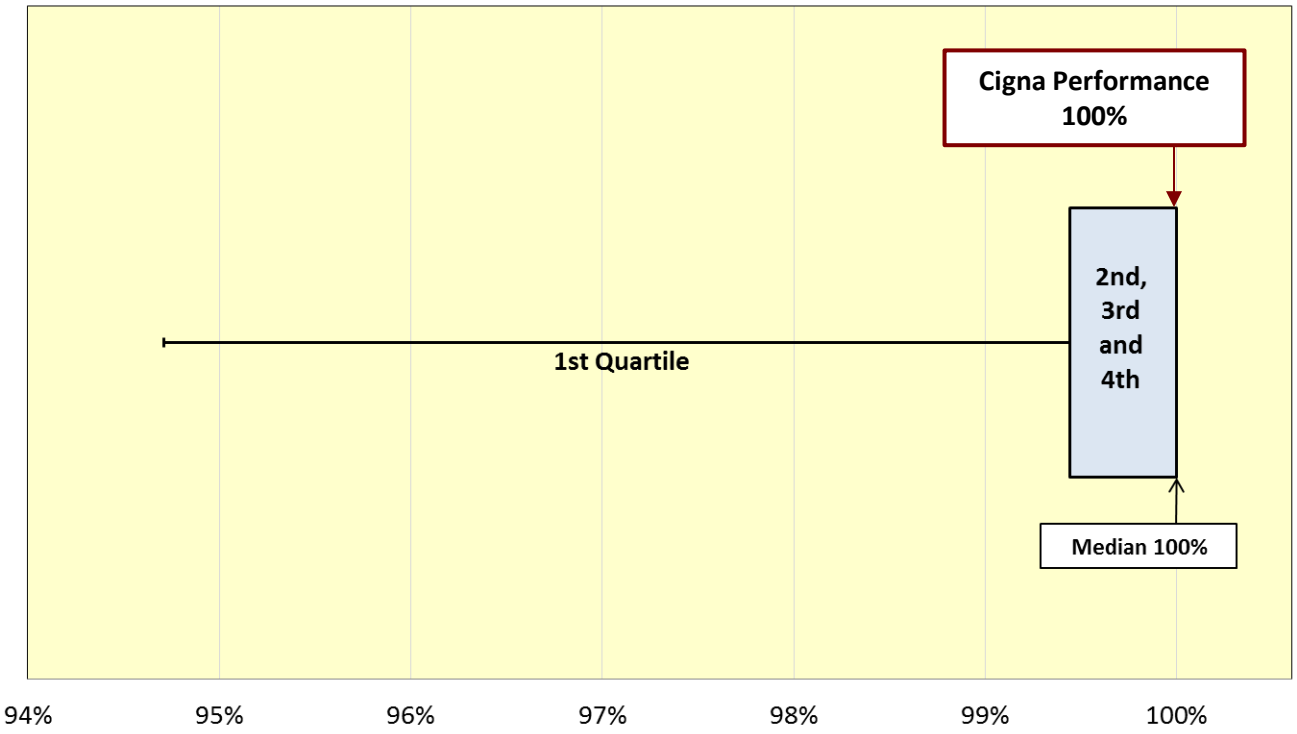


EXHIBIT B – Key Performance Indicators and Definitions

Financial Accuracy Rate – compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency – compares the number of claims paid correctly to the total number of claims paid.
Accurate Processing Frequency – compares the number of claims processed without errors of any type (financial or non-financial) to the total number of claims processed.
Adjudication Proficiency – compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Documentation Accuracy Financial – compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Documentation Accuracy Frequency – compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.

Claim Turnaround – the number of calendar days required to pay a claim from the date the claim was received by the administrator to the date a payment or denial was mailed.

EXHIBIT C – CIGNA'S RESPONSE TO DRAFT REPORT

Cigna's response to our draft report is on the following page

Cigna Response

Comprehensive Claim Administration Audit
Specific Findings Report
of

Cigna

for

State of Montana

July 2016

Executive Summary

Cigna would like to thank both the State of Montana and Claim Technologies Incorporated (CTI) for the opportunity to respond to the draft audit findings from the comprehensive claim administration audit conducted in our Denison, TX office the week of May 23, 2016.

The medical claim audit consisted of a Random, Stratified Sample of 180 claims; Targeted sample of 59 claims and an Operational Assessment Questionnaire.

The random claim sample selections were chosen from the time period of claims processed between January 01, 2015 and December 31, 2015. During this time period a total of 426,404 claims were processed representing $131,865,937.00 in claim payments. The random sample of 180 claims represented total dollars paid in the amount of $412,423.28, or 0.31% of the dollars paid.

For the random sample Cigna is in agreement with, and can confirm a total of 11 errors – three (3) overpayments totaling $65.74 and eight (8) underpayments totaling $15,425.42. In addition, there were a total of 17 "out of sample" underpayments totaling $9,085.95. For the Targeted sample, Cigna is in agreement with, and can confirm two (2) overpayments totaling $1,013.75.

Confirmed overpayments have been referred to Cigna's recovery vendor – Accent – and the underpayments have been correctly adjusted.

Cigna's audit methodology for determining accuracy results utilizes a 95% confidence level with a +/- 4% margin of error. Based on this methodology, we are proposing an alternative summary of audit results for the Random sample which does not include the three (3) errors in which we disagree. It is important to note that in calculating the audit results, CTI extrapolates the Financial Accuracy metrics however they do not extrapolate Payment or Processing Accuracy metrics. Cigna has extrapolated all three (3) accuracy metrics Additionally, the following categories, while recognized in CTI's audit report – Adjudication Proficiency and Documentation Accuracy (Financial and Frequency) – are not standard measures currently utilized by Cigna.

Therefore, Cigna recognizes the following results vs. CTI's calculations:

Financial Accuracy – 97.12% (vs CTI's calculation of 96.76%)
Payment Accuracy – 97.50% (vs. CTI's calculation of 92.22%)
Processing Accuracy – 97.50% (vs. CTI's calculation of 92.22%)

It is also important to note that there were two (2) claim errors within the sample (Sample #'s 5 and 56) that were corrected during the audit scope period. Based on

Cigna's experience, errors that are corrected within the scope period are typically not calculated in the audit findings. If we were to exclude these errors, as most audit firms in our experience do, the following results would have been achieved:

Financial Accuracy – 99.42% (vs CTI's calculation of 96.76%)
Payment Accuracy – 97.60% (vs. CTI's calculation of 92.22%)
Processing Accuracy – 97.60% (vs. CTI's calculation of 92.22%)

To address the specific errors identified, we have created a detailed Action Plan that addresses each issue and the steps taken for correction. The Action Plan is included in the following pages of this audit response and we look forward to meeting with the State of Montana to review the results of the audit and Cigna's corrective actions.

***Note:** Cigna has observed that CTI's sample selection methodology differs from what we have experienced in the industry. CTI chose the random, stratified claim sample using billed dollars and Cigna standardly observes claim samples chosen based on paid dollars. In comparison, when the auditing methodology utilizes paid amounts for the stratification rather than billed amounts, we would expect to see a larger percentage of paid dollars and/or more representation of higher dollar paid claims selected for review. For the State of Montana random sample, claims with payments less than $500.00 accounted for 33% of the total sample. In addition, when CTI calculates the results of the audit, the results are then calculated based on paid dollars.

It is important to note that Cigna is not stating that one methodology is more appropriate than another. We are noting that the differences that we have observed with CTI's methodology we do not see currently in the industry; in our experience with other external audit firms or with Cigna's own Performance Guarantee methodologies.

Although there are differences in certain methodologies, Cigna sincerely appreciates the insight and feedback shared by CTI as a result of this audit. We are dedicated to providing exceptional service to all State of Montana customers, and we are committed to taking the necessary actions to correct the errors identified as a result of this audit.

State of Montana
Summary of Client Audit Findings and Remediation
MEDICAL CLAIM AUDIT
Claims processed January 01, 2014 and March 31, 2016

OP = Overpaid
UP = Underpaid
OOS = Out of Sample

Audit Number	Error Category	Financial Impact	Root Cause	Corrective Action	Date Completed
1 25 72 108	Reimbursement	OP $65.43 UP $731.87 OP $0.01 OP $0.30	Allowed Amounts Applied Incorrectly (Manual)	1. Overpayment refund requests forwarded to Accent on 06/14/2016 for #'s 1 - 72 - 108 2. Underpayment correctly adjusted 06/17/2016 for # 25 3. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Refresher review of the claim and the Proclaim Pricing Guidelines SOP with specific attention to allowance of the contract. - In Network vs. Non Par processing - Review of the Manual Claim Overrides SOP and Overrides Codes Guide - Discussion included the necessity to always verify the claim/service level calculations to ensure the correct allowables are reflected, including the OOP. - Review of steps for proper adjudication of the pricing allowables. - A refresher reminder to follow the Claim Processing checklist. - Error review will be conducted with the team by the Supervisor/Quality Coach to assure overall understanding	1. Pending recovery 2. 06/17/2016 3. 05/25/2016; 06/02/2016 & 07/06/2016
5 141 146 152 172 173	Other Insurance / Medicare	UP $14,100.73 UP $39.90 UP $7.37 UP $60.51 UP $0.66 UP $40.86	Cigna Prime; Medicare EOB requested in error / Other Insurance & Medicare allowable applied incorrectly (Manual)	1. Underpayment for Sample # 5 was adjusted prior to audit on 02/06/2015 (15 days after initial denial). 2. Remaining underpayments correctly adjusted on 06/21 & 06/22/2016. 3. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Medicare application reinforcement coaching - Medicare Proclaim Processing SOP	1. 02/06/2015 2. 06/21 & 06/22/2016 3. Between 05/27 & 06/29/2016
OOS 5 OOS 11 OOS 54 OOS 55 OOS 57 OOS 61 OOS 86	Benefit / Coinsurance Application	UP $4.42 UP $47.81 UP $2,911.70 UP $20.00 UP $3,300.91 UP $4.81 UP $376.38	Out of Pocket (OOP) over accumulated (Manual)	1. Underpayments correctly adjusted between 06/17 and 06/22/2016. 2. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Manual Claim Overrides SOP and Overrides Codes Guide - Review of necessity to ensure proper verification of claim/service level calculations to ensure the correct allowables are reflected, including OOP	1. 06/17; 06/21 & 06/22/2016 2. 05/25; 05/26; 06/08 & 06/29/2016
OOS 15 OOS 18 OOS 22 OOS 26 OOS 31 OOS 36 OOS 38 OOS 39 OOS 43 OOS 55 OOS 68 OOS 86	Benefit / Copay & Coinsurance Application	UP $100.00 UP $97.42 UP $400.00 UP $300.00 UP $200.00 UP $400.00 UP $55.51 UP $200.00 UP $100.00 UP $67.09 UP $400.00 UP $100.00	Emergency Room (ER) copayment should have been applying to the Out of Pocket (OOP).	1. Underpayments were correctly adjusted on between 06/17 & 06/23/2016. 2. Benefit correction completed on 10/22/2015. 3. Claim impact reporting was requested and is currently in review. Cigna will provide outcome of additional findings once completed.	1. 06/17; 06/22; 06/23 2. 10/22/2015 3. In progress
56	Reimbursement	UP $443.52	Multiple Surgery Reduction should not have applied to this provider.	1. Claim adjusted prior to audit on 05/29/2015, six (6) days after initial claim processing 2. Cigna has in place a process to ensure that claims for this provider that apply the Multiple Surgery Reduction are quickly adjusted as appropriate. This is a system edit to capture all claims in this category. The process has been in place since February 10, 2014.	1. 05/29/2015 2. Ongoing process

ESAS 10	Reimbursement	OP $500.00	Payment of non-covered expense (Orthotics) (Manual)	1. Overpayment refund request forwarded to Accent on 06/14/2016 2. Coaching provided to individual processor on 06/07/2016. Error also reviewed with claim team for further improvement opportunity. Focused of coaching included: Review of Claim Processing Checklist Benefit Verification and review of online Benefit Access tool 3. Cigna is currently reviewing impact reporting received from CTI on 6/29/2016, however we have requested clarification via email and are awaiting CTI's response. Once claim impact reporting is reviewed, Cigna will provide outcome of additional findings upon completion.	1. Pending recovery 2. 06/07/2016 3. In progress
ESAS 11	Reimbursement	OP $513.75	Payment of non-covered expense (Elective Abortion) (Manual)	1. Overpayment identified prior to the audit and refund requests forwarded to Accent on 03/26/2016. 2. Coaching provided to individual processor on 06/07/2016. Error also reviewed with claim team for further improvement opportunity. Focused of coaching included: Review of Claim Processing Checklist Benefit Verification and review of online Benefit Access tool 3. Claim impact reporting was requested and is currently in review. Cigna will provide outcome of additional findings once completed.	1. Pending recovery 2. 06/14/2016 3. In progress
ESAS 5	*Benefits*	*OP $1,722.32*	*CTI's position is that an MRI services for TMJ should have been denied.*	*Cigna continues to respectfully disagree.* *The benefit exclusion for TMJ for the State of Montana states that non-surgical treatment of TMJ is not covered. An MRI is not considered "treatment", but is a diagnostic service. In addition, there was a medically necessary Authorization on file for this claim.* *Based on this information, no further review of claims is warranted.*	
7 *ESAS 6* *ESAS 7*	*Timely Filing*	*OP $643.84* *OP $4,081.72* *OP $921.96*	*CTI's position is that these claims should have been denied for Timely Filing*	*Cigna continues to respectfully disagree.* *Cigna has specific Standard Operating Procedures (SOP), which were provided to CTI during the onsite audit. The SOP states that in the cases when Cigna is secondary to other insurance, we have two (2) years in which to process the claims. This allows our customers the opportunity and time to ensure that the primary insurance is billed and payment made, before submitting to Cigna as the secondary payor.* *In addition, on Sample # ESAS 7, proof of timely filing was provided to CTI. On this claim, the provider provided proof that the claim was mailed to the incorrect address. Per call into Cigna's Customer Service Team, the provider was instructed to submit the claim to the correct address for payment* *Based on this information, no further review of claims is warranted.*	
ESAS 8	*Benefit*	*Additional Observation*	*CTI's has indicated that Cigna does not use the Medicare Physician Fee Schedule Data Base to determine payment policy related to modifiers 26 or TC to lab codes.*	*Cigna continues and will continue to allow payment of automated labs. It has been determined by the courts that a pathologist is entitled to a fee for supervising the lab and its quality control. While other payers (like CMS) have other methods to reimburse the pathologist for this service, Cigna does not.* *In addition, Cigna utilizes coding rules, following the American Medical Association Guidelines.* *Based on this information, no further review of claims is warranted.*	
ESAS 9	*Benefit*	*Additional Observation*	*CTI's recommendation is that the SPD requires an update specifically related to which parts of hearing aids are not covered.*	*Cigna will be happy to work on this potential SPD update directly with the State of Montana.* *The claim identified in the Targeted audit was processed correctly, therefore no further review of claims is warranted.*	
ESAS 12	*Benefit*	*OP $252.89*	*CTI's position is that all services and supplies related to sexual inadequacy or dysfunction are to be excluded.*	*Cigna continues to respectfully disagree.* *The services allowed and paid were for a standard office visit, not for treatment of sexual inadequacy or dysfunction.* *Based on this information, no further review of claims is warranted.*	

ESAS 21	*Subrogation*	*OP $85.68*	*CTI's position is that this claim should have been investigated for potential 3rd party liability, relative to Workers' Compensation*	*Cigna has provided this example to our Subrogation vendor - Xerox - for review.* *The diagnosis code in question - V62.1 - is part of the code range V60-V63 that relates to other psychosocial/economic circumstances and therefore this code has not historically been investigated as it appears to be used when treating mental health issues. Given the sensitivity to mental health care and the wide diagnosis included in the code range, review of these circumstances is not warranted.* *- All other diagnosis codes provided by CTI for potential subrogation investigation are currenlty included in Xerox processes.* *- Cigna has previously provided complete Subrogation Reports to the State of Montana for their review*	
ESAS 24	*High Dollar Claim Review*	*Procedural Deficiency*	*CTI's position is that Cigna's procedures should be reviewed to ensure that all levels of review and approval are being consistently applied.*	*Upon further review, we have confirmed that this claim did go through Cigna's high dollar claim review process.* *Cigna continues to respectfully disagree with the error assigned by CTI. The claim was processed correctly.*	
ESAS 26	*Negotiated Fee Reduction*	*Additional Observation*	*CTI's recommendation is that Cigna should review with the State of Montana why no attempt at obtaining a fee reduction was undertaken.*	*Cigna is currently reviewing the recommendation from CTI, along with the claim, and will advise.*	
General	*Provider Discounts and Fees*	*Additional Observation*	*CTI has observed that there are were in network services where the allowed amount was greater than UCR at the 80%*	*Cigna contracted providers are reimbursed at their contracted rates. UCR would not be applicable in these instances.*	
81	*Benefit / Copay Application*	*UP $8.45*	*CTI's position is that $20.00 copayment should not have applied to supply charges related to an MRI.*	*Cigna continues to respectfully disagree.* *Cigna has an internal SOP (provided to CTI during the onsite audit) that states that charges for items such as contrast material, dyes, etc. are subject to the applicable place of service coinsurance, deductible and/or place of service copayment level of benefits. $20 copayment for office place of service is correct in this instance.*	
134	*Reimbursement*	*OP $370.00*	*CTI's position is that services rendered should have only been reimbursed four (4) times due to "Targeted Case Management per month".*	*Cigna continues to respectfully disagree.* *As provided during the onsite audit, based on the Montana State Statute (# 33-22-515), the statute states the following related to this claim scenario: b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for autism spectrum disorders provided for under this section.* *Therefore, Cigna considers the sample claim processed correctly.*	

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Comprehensive Claim Administration Audit

EXECUTIVE SUMMARY

State of Montana Dental Plans
Administered by Delta Dental Insurance Company

Audit Period: January 1, 2014 through December 31, 2015

Presented to

State of Montana

May 25, 2016

Presented by

Claim Technologies Incorporated
known in Montana as CTI Claim Audit Technologies Corp.

TABLE OF CONTENTS

INTRODUCTION

This ***Executive Summary*** contains findings and recommendations from Claim Technologies Incorporated known in Montana as CTI Claim Audit Technologies Corp. (CTI's) comprehensive audit of Delta Dental's (Delta's) claim administration of the State plan. Supporting detail for these findings and recommendations are in the ***Specific Findings Report***.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Delta Dental and CTI in their efforts to serve the interests of the plan participants of the State of Montana Dental Plans. All findings are based on the data and information provided to CTI by Delta and the State. Therefore, the validity of the findings relies heavily upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between Delta and the State as well as the approved benefit descriptions (summary plan descriptions, plan document or other communications).

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the administrator's policies, processes and systems as they apply to the State's paid claims during the audit period.

OBJECTIVES AND SCOPE

Audit Objectives

The specific objectives of CTI's comprehensive audit of Delta's claim administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for the administrative services between the plan sponsor and claim administrator were followed;
- Determine whether claims were paid according to the provisions of the summary plan description (SPD) and the terms of the SPD were clear and consistent;
- Determine whether members were eligible and covered by the sponsor's dental plans at the time a service paid by Delta was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a comprehensive audit of Delta's claim administration of the State's dental plan(s) for the 24-month period of January 1, 2014 through December 31, 2015. The random sample audit component included the 12-month period of January 1, 2015 through December 31, 2015. For the random sample audit period, the population of claims and amount paid by the plan were:

Total Paid Amount	$7,751,674
Total Number of Claims Paid/Denied/Adjusted	57,301

The audit included the following components which, when viewed together, provided evidence that allowed us to produce this report.

- Random Sample Audit of 108 claims
- 100% Electronic Screening with 10 Targeted Samples (ESAS®)
- Plan Documentation Review
- Operational Review
- Data Analytics

CTI's findings in each of the audit components and our recommendations follow.

KEY FINDINGS

Random Sample Audit

Methodology

CTI validated the accuracy of claims processing based on a sample of 108 dental claims paid or denied by Delta during the audit period. We selected the random sample (stratified by the claim billed amount and the date processed) to provide a statistical confidence level of 95% +/- 3% margin of error. Our audit system classified errors identified through the sample by type and frequency. CTI then requested input and additional documentation from Delta about the potential errors. CTI's initial determination of an error was provided to the administrator in a working draft report. The administrator was given the opportunity to provide additional information in its response to the working draft. This additional response was considered when compiling our reports.

Findings

CTI's random sample audit system categorizes errors into Key Performance Indicators. This systematic labeling of errors and calculation of performance is the basis for CTI's benchmarks that are generated using the most recent dental claim administration audits completed by CTI.

The following table demonstrates that Delta's performance was below the median average in CTI's benchmarked Key Performance Indicators. For more specific information on our benchmarks and how the administrator performed in this audit, see the box and whiskers charts in Exhibit A.

Key Performance Indicators	Administrator's Performance by Quartile			
	Quartile 1	Quartile 2	Quartile 3	Quartile 4
Financial Accuracy Rate				
Accurate Payment Frequency				
Accurate Processing Frequency				
Adjudication Proficiency				
Documentation Accuracy – Financial				
Documentation Accuracy – Frequency				

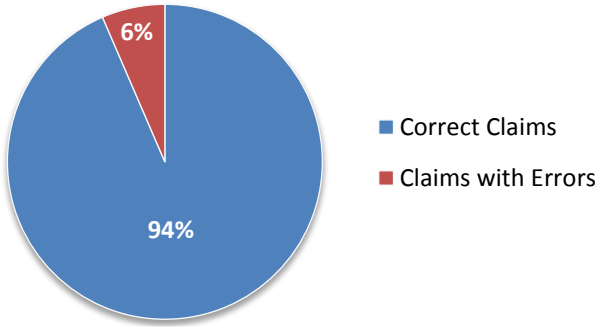
Key	Quartile 1	Quartile 2	Quartile 3	Quartile 4
				
	Lowest Performance			*Highest Performance*

The definition for each Key Performance Indicator is in Exhibit B.

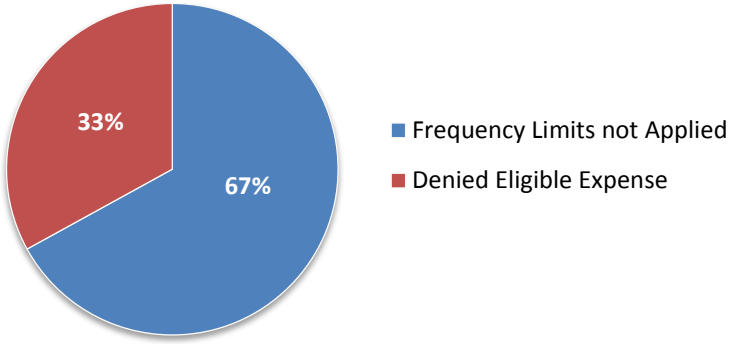
Prioritization of Process Improvement Opportunities

The following charts will help to prioritize improvement and/or recovery opportunities based on savings and service impact; and in pinpointing problem causes. The recommendations section of this report provides next steps to achieve improvement and discussion.

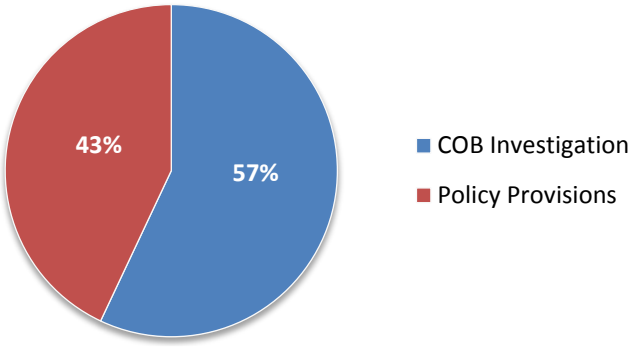
Overall Accurate Processing Frequency



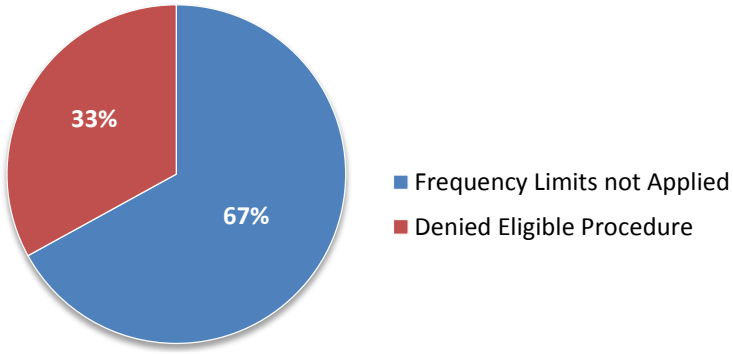
Financial Accuracy by Error Type



Accurate Processing Frequency by Error Type



Policy Provision Errors by Type

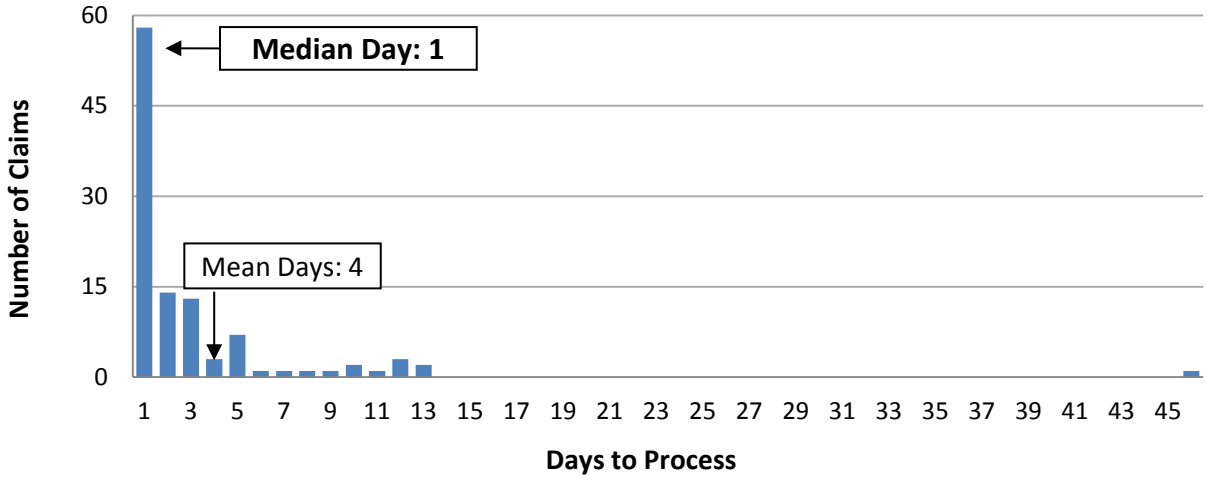


Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Delta demonstrated that its median turnaround time on a complete claim submission was one day from the date it received a complete claim to the date it was paid or denied. It should be noted that one of the 108 claims in the sample took greater than 45 days to pay.

CTI does not have a benchmark for this measure; instead, we illustrate the distribution of turnaround time for claims in the following chart.

Median and Mean Claim Turnaround



100% Electronic Screening with Targeted Samples (ESAS®)

Scope and Methodology

CTI employed our proprietary ESAS software to further analyze claim payment accuracy and opportunities for system and process improvement. We screened 100% of claims paid or denied during the audit period plus the previous 12 months and auditors selected a targeted sample of 10 electronically screened claims to validate findings and test Delta's claim administration systems.

Findings
CTI found no errors in Delta's processing as a result of our testing of claims selected for targeted review following electronic screening. CTI recommends Delta continue its diligent attention to claims in categories of control risk to avoid financial exposure to the State's plan.

Operational Review

Scope and Methodology
Delta completed our operational review questionnaire that provided information on the administrator's:

- Systems, staffing and workflow;
- Claim administration and eligibility maintenance procedures; and
- Internal control risk mechanisms e.g., HIPAA protections; internal audit policies and practices; and fraud, waste and abuse detection and prevention.

Findings
Our operational review indicated that:

- Delta provided insurance certificates documenting its levels of coverage for errors and omissions (E and O), its fidelity bond, and cyber liability. The coverage levels comply with the limits specified in the State's Third Party Administration Agreement. The E and O and cyber liability coverage certificate is issued to Dentegra Group, Inc. and the fidelity bond is issued to Delta Dental of California and its subsidiaries. Delta should provide written confirmation that it is covered as an insured under these policies.
- Delta provided a copy of its self-reported results against performance guarantees specific in its Third Party Administration Agreement. CTI's independent audit confirmed that Delta's performance exceeded contractual guarantees for claims accuracy.
- Delta has very effective procedures for recovery of overpayments. If an overpayment is made to a participating dentist, the overpayment is recovered by withholding payment from future checks. Overpayments made to members are recovered by flagging the member and applying the overpayment before additional payments are made. If Delta is responsible for an overpayment and funds cannot be recovered, it will credit the State's account at its own expense for the amount of the overpayment.
- Delta's claim system includes internal flags so that claims which require professional review are referred to dental consultants prior to being paid. This is an effective internal control to ensure the dental necessity and reasonableness of claim payment. In addition, Delta's consulting dentists are the only claim processors with authority to override fee determinations.
- Delta has adequately documented training, workflow, procedures and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- Delta has no procedures for investigating eligibility of dependents and relies on the State for providing accurate eligibility status.

- Delta collects information about other dental coverage during initial enrollment and accepts updates to other coverage information submitted with eligibility at any time. Following entry of initial coordination of benefits (COB) information, subsequent validation is performed on a claim-by-claim basis. CTI noted during the random sample audit that Delta relies on information from providers as the basis for COB information, rather than independently investigating the potential for other coverage.
- Delta updates its fees at least annually based on many factors including network size, overall discount and competitive market conditions. In Montana, Delta PPO fees are 24% less than submitted charges. The Delta Dental Premier fees were 15% less than average submitted charges. These discount levels were confirmed during CTI's independent analysis.
- Although Delta did not provide copies of its policies and procedures confirming HIPAA compliance, because it considers them confidential and proprietary, it did provide a general statement about its implementation of comprehensive policies and procedures that address required protections for privacy and security.
- Training on HIPAA security and privacy requirements is required for all new employees and other employees receive refresher training annually.

Plan Documentation Review

Scope and Methodology

CTI evaluated the summary plan description (SPD), plan documents, member handbooks and contract(s) between the State and Delta for clarity and consistency. We then created a benefit matrix to identify inconsistencies and/or missing provisions that needed to be clairifed with the State. Once clarified, our auditors used the matrix as a cross reference tool as they audited claims.

Findings

Our plan documentation review indicated the State's summary plan description:

- Contained no ambiguities. We note, however, that Delta has disagreed with some of the errors cited by CTI because of provisions in agreements or guidelines in place with participating dentists. If the State agrees with Delta's guidelines, these coverage limitations should be included in coverage documents.

Data Analytics

Network Provider Utilization and Discount Savings

CTI compared submitted charges to allowable charges for all claims paid during the audit period for the plan(s). The analysis relied on the data provided by the administrator and no assumptions were made when necessary data fields were not provided. The following table shows the results of CTI's analysis of the value of discounts given by network providers as a percentage of all claims processed during the audit period.

Total of All Claims				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$0	$0	0.0%	$0
Non-Facility	$14,603,291	$4,358,237	29.8%	$7,745,964
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total	**$14,603,291**	**$4,358,237**	**29.8%**	**$7,745,964**

Utilization of network or secondary network providers by the State members was 66.3% of all allowed charges and 70.5% of all claims. This is consistent with the distribution of network providers and their availability to members throughout the State of Montana.

RECOMMENDATIONS

Based on the findings of our comprehensive audit of Delta, we make the following recommendations to the State:

1. Meet with Delta to discuss the audit findings and focus specifically on the steps necessary to improve Financial Accuracy, Accurate Payment Frequency, Accurate Processing Frequency and Documentation Accuracy (both Financial and Frequency). To facilitate this discussion, you should request that Delta review each of the financial errors identified by our random sample audit and determine if system changes should be made to reduce or eliminate errors of a similar nature in the future. The discussion should focus on these issues:
    a. Modification to Delta's system so that it captures information for partial, rather than exact, matches for tooth surfaces. This enhancement would improve Delta's potential for accurate payment of claims.
    b. Coverage for oral surgery procedures that are covered under the State's summary plan description, but which are not covered based on Delta's Dentist Handbook.
    c. Delta's procedures for identifying claims where there may be double dental coverage and application of primary and secondary processing guidelines, along with notations of those determinations within the claim system.
2. Discuss language in the coverage documents that provides benefits for services which Delta excludes based on its Dentist Handbook.
3. Confirm that evidence of insurance provided by Delta, which does not specifically mention Delta Dental Insurance Company (DDPI), includes coverage for DDPI even though the policy is issued to third parties.
4. Review Delta's list of participating dentists and identify opportunities for additional network contracting to broaden the number of network dentists available to employees of the State of Montana.
5. Perform a follow-up audit to verify recommended improvements have been made, performance results against benchmark are improving, and that no new processing issues arise.

We understand that you will need to review these recommendations to determine the subject of immediate action. Should the State decide that additional assistance in implementing or performing any of the required tasks would be beneficial, our contract offers 10 hours of post-audit time to provide you with further assistance.

Delta cooperated with this audit and made every effort to provide us with the data and documentation we requested.

We have considered it a privilege to have worked for, and with, your staff and would welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

EXHIBITS

A. Performance Measurements and Benchmarking

B. Key Performance Indicators

C. Delta's Response to Audit Report

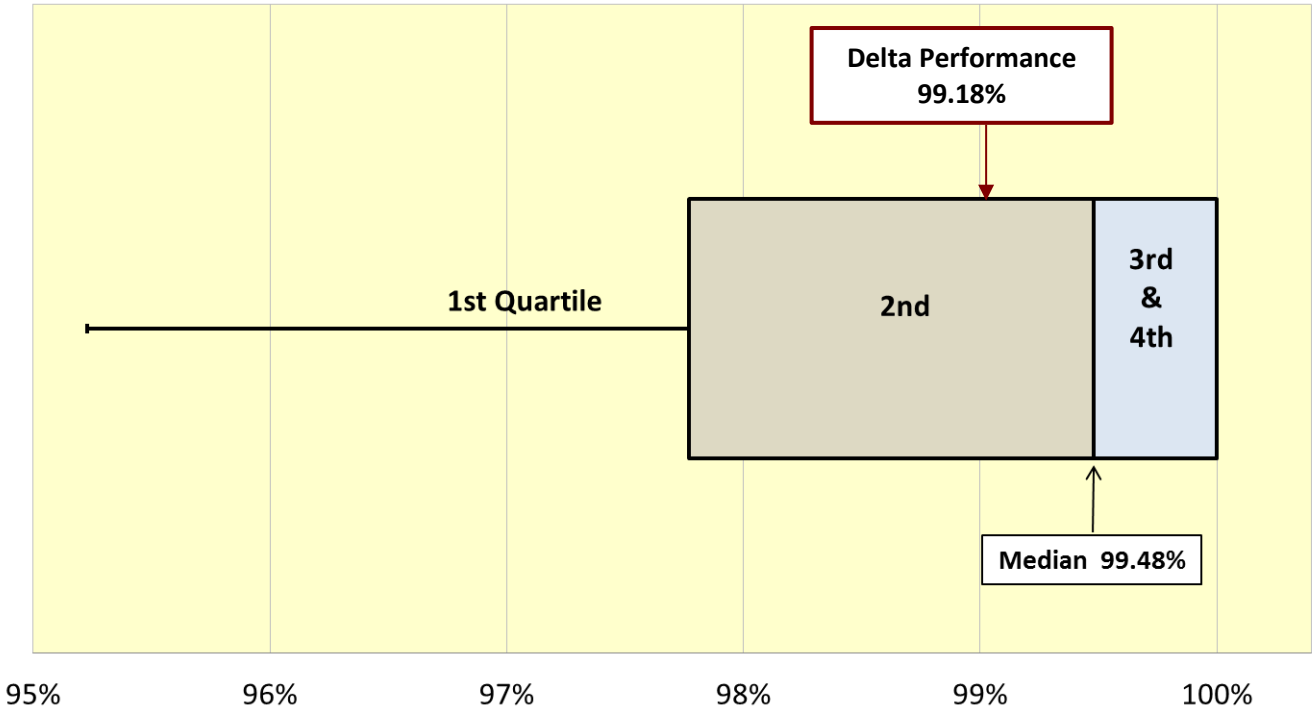
EXHIBIT A – Performance Measurement

The following box and whisker charts are based on the most recent dental claim administration audits performed by CTI. The charts are used to demonstrate the administrative performance when compared to the other plans against each of our Key Performance Indicators.

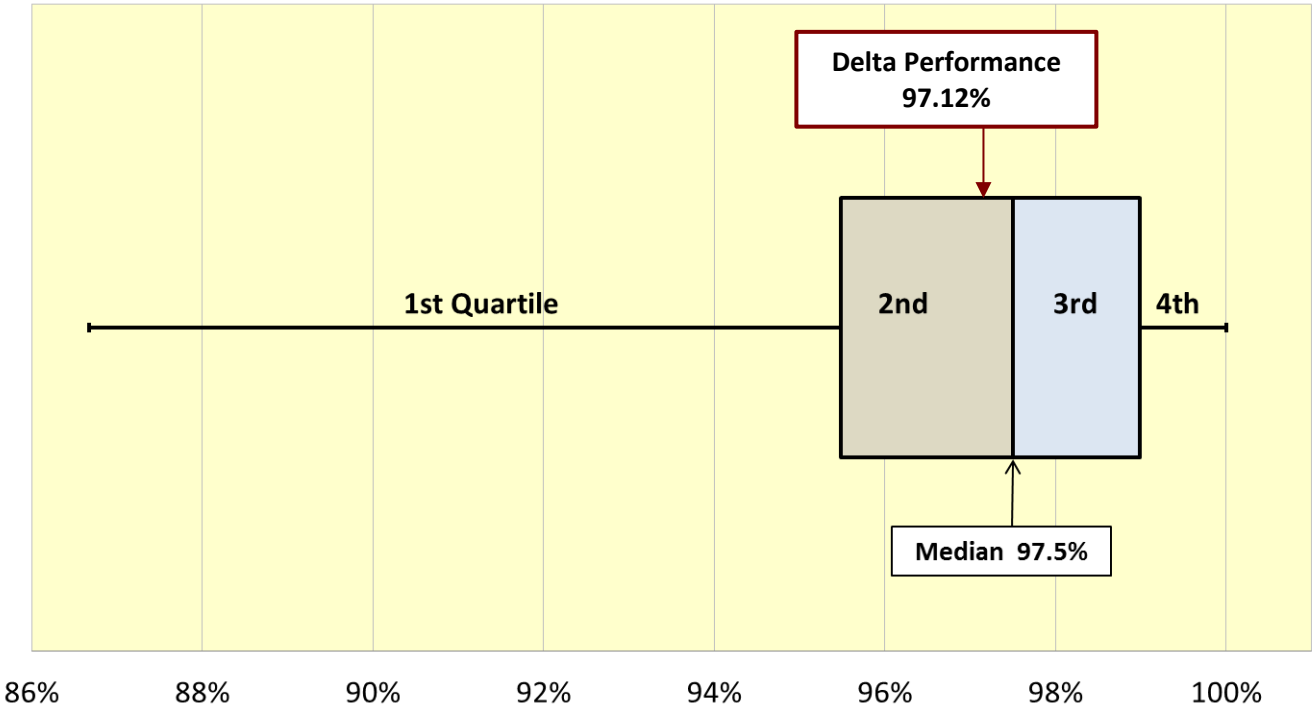
Each chart contains the following information:

- Delta performance
- Benchmark performance
- Lowest performance
- Performance levels by quartile – with the 4th quartile representing the highest performing plans and the 1st quartile representing the lowest performing plans
- Performance level relative to the Median – or the level at which half of the plans audited were higher and half were reported to be lower. An administrator may achieve a seemingly high result for a performance measure, yet when compared to the performance of other administrators arrayed by quartile, performance may indicate an opportunity for improvement.

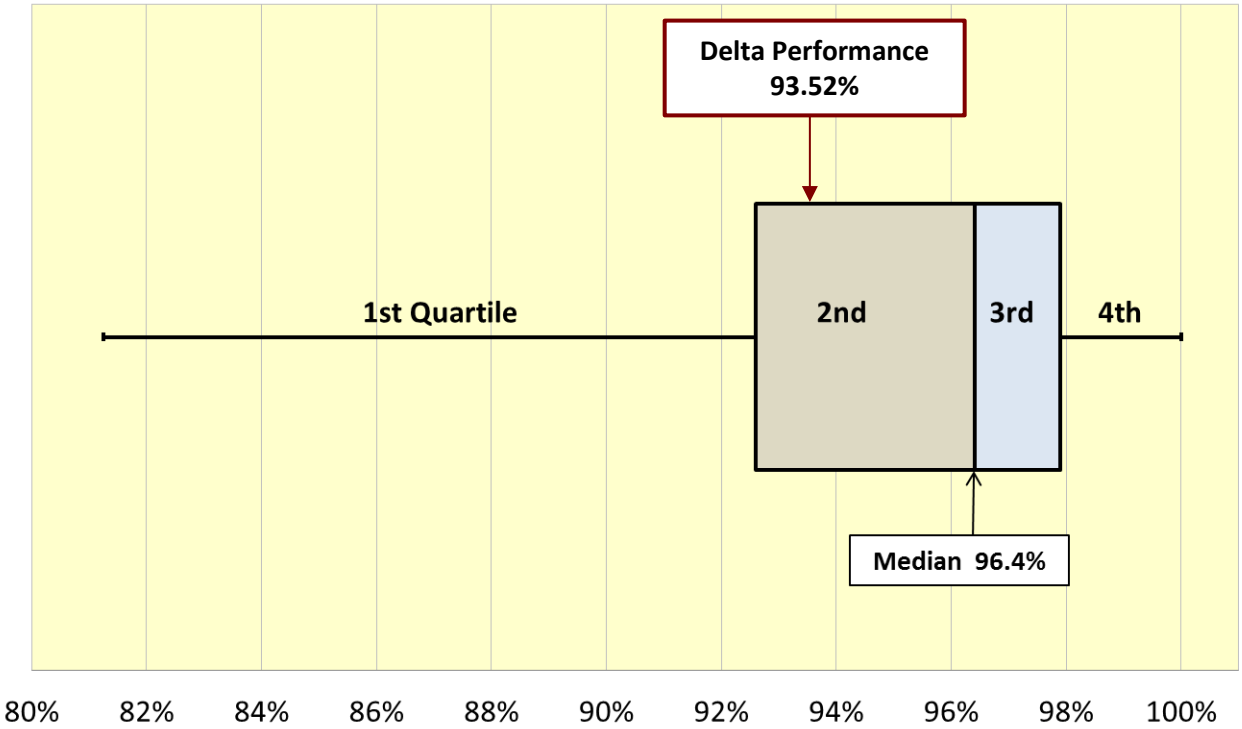
Financial Accuracy Rate – Performance vs. Other CTI Plans Audited by Quartile



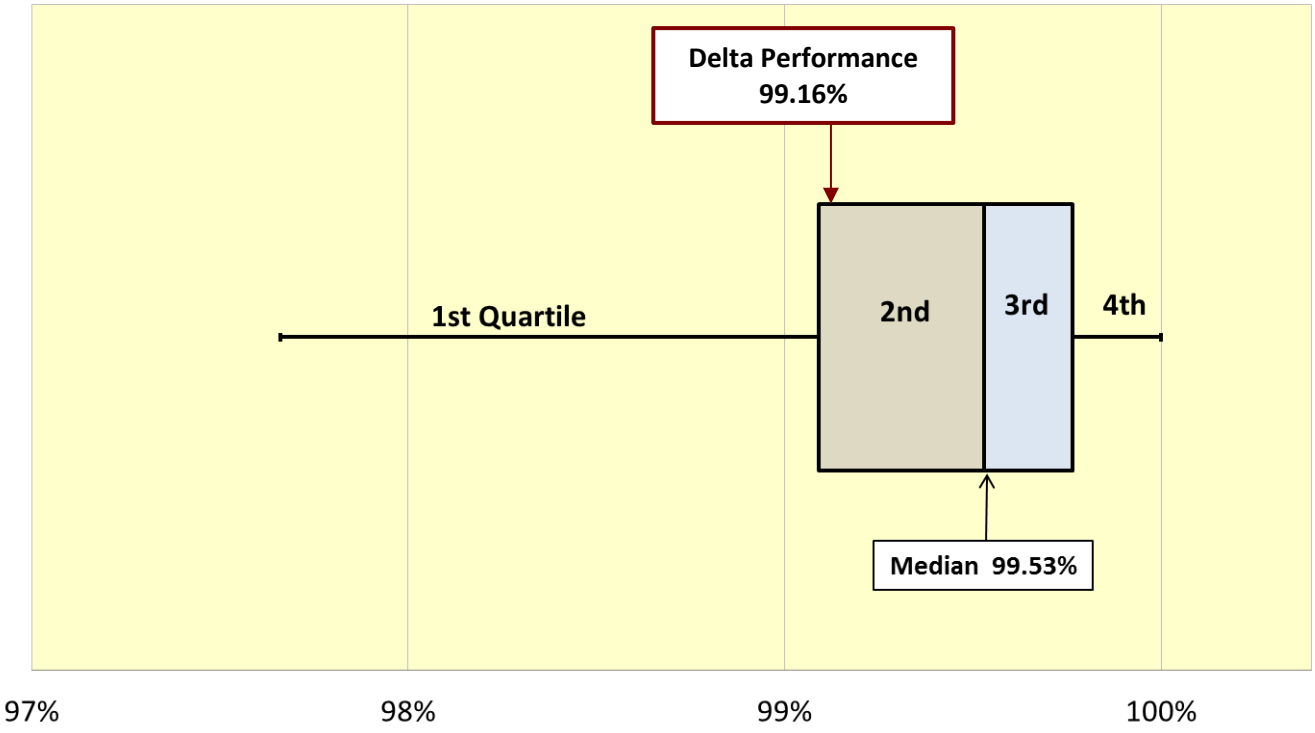
Accurate Payment Frequency – Performance vs. Other CTI Plans Audited



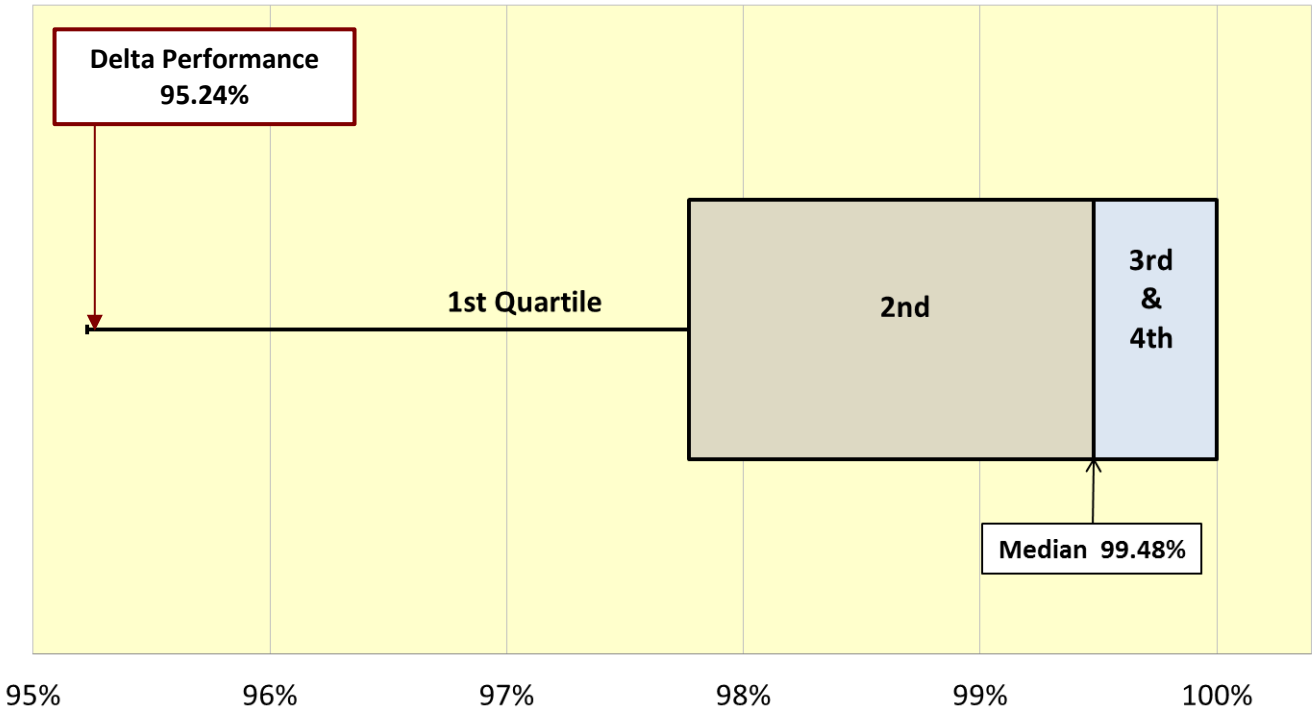
Accurate Processing Frequency – Performance vs. Other CTI Plans Audited



Adjudication Proficiency – Performance vs. Other CTI Plans Audited



Documentation Accuracy Financial – Performance vs. Other CTI Plans Audited



Documentation Accuracy Frequency – Performance vs. Other CTI Plans Audited

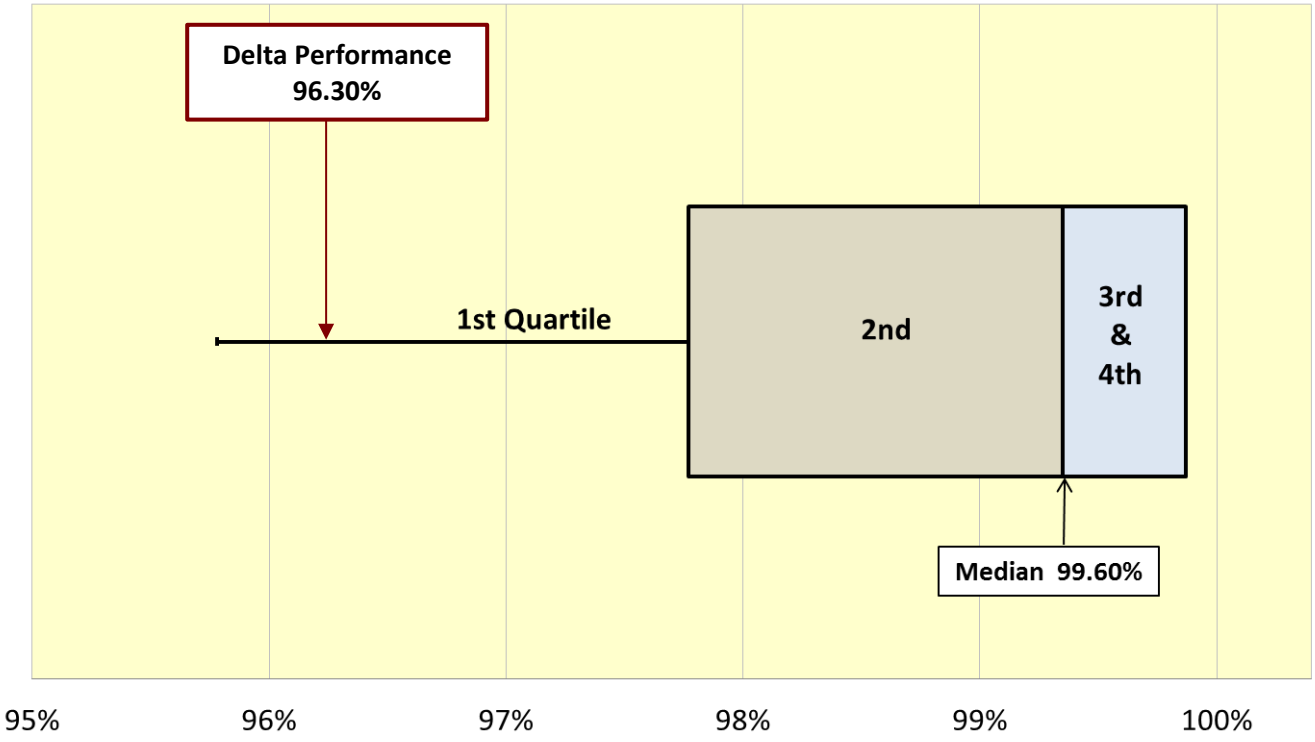


EXHIBIT B – Key Performance Indicators and Definitions

Financial Accuracy Rate – compares the total dollars associated with correct claim payments to the total dollars of correct claim payments that should have been made.
Accurate Payment Frequency – compares the number of claims paid correctly to the total number of claims paid.
Accurate Processing Frequency – compares the number of claims processed without errors of any type (financial or non-financial) to the total number of claims processed.
Adjudication Proficiency – compares the number of correct adjudication decisions made to the total number of adjudication decisions required.
Documentation Accuracy Financial – compares the number of dollars processed with documentation adequate to substantiate payment or denial to the total number of dollars processed.
Documentation Accuracy Frequency – compares the number of claims processed with documentation adequate to substantiate payment or denial to the total number of claims processed.

Claim Turnaround – is the number of calendar days required to pay a claim from the date the claim was received by the administrator to the date a payment or denial was mailed.

EXHIBIT C – Delta's Response to Draft Report

Delta's response to the draft report follows

DELTA DENTAL

Delta Dental Insurance Company

April 25, 2016

Mr. Daniel Montgomery
Claim Technologies Incorporated
100 Court Ave., Suite 306
Des Moines, IA 50309

Re: The State of Montana – Audit Report

Dear Dan:

Thank you for the opportunity to review the draft audit report for our mutual client, The State of Montana. As always, CTI has done a thorough and comprehensive review of Delta Dental and we appreciate the opportunity to partner with you to identify areas where we can improve service to The State of Montana and its members.

The State of Montana is a long-time valued and important client of Delta Dental. As such, we want to assure that we are meeting their expectations at all times. We wanted to highlight a few items for clarification and comments based on our review of the audit report:

1. CTI # 1009: Delta Dental disagrees. Claim submitted with procedure D2393 (Amalgam – four or more surfaces) on tooth # 30. Tooth #30 is in history for surface DO. The claim is allowed to pay since it was processed under a different Tax ID (Provider) than the claim in history. The claim properly adjudicated based on our processing policies.
2. CTI # 1055: Delta Dental disagrees. Both restorations, D2391 (Resin-based Composites – one surface), were allowed on tooth # 19 because our system does not do partial surface matches. The claim system will only deny payment when there is an exact surface match. Procedure was done at the same practice location. The claim properly adjudicated based on our processing policies.
3. CTI # 1087: Delta Dental disagrees. D7953 (Bone Replacement Graft) is not a covered benefit of the State of Montana plan. Claim processed correctly.

We look forward to jointly discussing the results of this audit at a future meeting. Once again, thank you for your continued partnership.

Sincerely,

Chris Hinds
Director, Sales

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Prescription Benefit Management Audit

EXECUTIVE SUMMARY

State of Montana
Administered by MedImpact

Audit Period: January 1, 2014 – December 31, 2015

Presented to

State of Montana

August 16, 2016

Prepared by

TRICAST LLC

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PREFACE

This ***Executive Summary*** presents key findings and recommendations from TRICAST, LLC, as subcontractor for Claim Technologies Incorporated (CTI), for its audit of MedImpact's administration of the State of Montana pharmacy benefit plan(s). The information that these key findings and recommendations are based upon is detailed in the ***Specific Findings Report***.

These audit findings are based on data and information the State of Montana, as the plan sponsor, and MedImpact, as the Pharmacy Benefit Manager (PBM) provided to TRICAST and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between MedImpact and the State of Montana as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the State of Montana.

TRICAST is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by TRICAST in this report and the ***Specific Findings Report*** relate narrowly and specifically to the overall efficacy of MedImpact's policies, processes and systems relative to the State of Montana's paid claims during the audit period.

TRICAST, LLC

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OBJECTIVES AND SCOPE

Audit Objectives

The objectives of TRICAST's audit of MedImpact's pharmacy benefit management were to determine if:

- MedImpact adhered to the contractual and pricing terms outlined in the agreement with the State of Montana;
- MedImpact accurately administered benefit provisions;
- MedImpact is compliant with all Health Insurance Portability and Accountability Act (HIPAA) policies and procedures;
- MedImpact is performing agreed upon Coordination of Benefit (COB) duties;
- MedImpact is meeting contractually approved Performance Guarantees; and
- Potential for fraud, waste and abuse against the pharmacy plan(s) was monitored and controlled by MedImpact.

Audit Scope

TRICAST's audit encompassed the contract in force and the pharmacy benefit claims administered by MedImpact for the audit period of January 1, 2014 through December 31, 2015. The State of Montana's population of claims and the total net plan paid (equals total payment less member copayment) during this period:

Total Number of Prescription Drug Claims Paid	964,277
Net Plan Paid	$79,083,923

The audit included the following seven components.

1. **Pricing and Fees Audit**
2. **Reconciliation of Pricing Guarantees**
3. **Benefit Payment Accuracy Review**
4. **HIPAA Compliance**
5. **Coordination of Benefits (COB)**
6. **Performance Guarantees**
7. **Fraud, Waste and Abuse (FWA)**

Auditor's Conclusion

The audit TRICAST performed was a comprehensive assessment of MedImpact and its operations as they pertain to the State of Montana Prescription Drug Plan(s). The audit entailed significant exchange of information and data between TRICAST and MedImpact. Based on our findings, and in our opinion, MedImpact:

- Filled the claims in accordance with the benefit design
- Did meet the contract discount rates at retail for various categories of drugs
- Maintained operational business processes in-line with industry standards

Specific objectives, findings and recommendations for each of the seven components of this audit can be found in this report.

KEY FINDINGS AND RECOMMENDATIONS

Pricing and Fees Audit

The Pricing and Fees Audit verified if prescription drugs were processed according to the discounts and fees specified in MedImpact's contract with its network pharmacies. After a thorough forensic verification of the electronic claim data provided by MedImpact, TRICAST systematically re-priced 100% of paid prescription drug claims to determine that:

- Discounts were applied correctly based on the lessor of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP) and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Any errors identified in pricing or fees were shared with MedImpact. Details of the discussion of those errors between TRICAST and MedImpact can be found under separate cover in the ***Specific Finding Report***.

Findings and Recommendations

Our Pricing and Fees Audit found that discounts were accurately programed and applied by MedImpact. However TRICAST observed one area relative to adjudication of mail claims that resulted in the contracted discounts for mail generic claims under-performing according to AmeriPharm contracted discount rates. The total amount of under-performance during the audit period was $187,361. TRICAST recommends that the State of Montana work with MAHCP to ensure no money is owed for missed mail guarantees since the contract is measured and reported at the MAHCP level.

Reconciliation of Pricing Guarantees

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in the MedImpact contract with the State of Montana were met and if not met, that accurate credit or payment was made to the State of Montana within the time frame specified in the contract.

TRICAST used its proprietary AccuCAST® system to electronically compile total discount savings by silo (drug type and distribution method) and compare them to the contract guarantees in the MedImpact contract. If the MedImpact's performance fell short of any of the guarantees, we validated that the PBM recognized the shortfall and subsequently credited or paid the difference to the State of Montana.

Findings and Recommendations

Our Reconciliation of Pricing Guarantees found that AmeriPharm fell short of the minimum mail generic discount levels stipulated in the contract by $187,361. TRICAST recommends that the State of Montana verify with MAHCP to ensure no money is owed for missed guarantees.

With the exception of the above finding TRICAST found that the performance guarantees in the State of Montana/MedImpact contract were accumulated correctly and were met or exceeded.

Benefit Payment Accuracy Review

The objective of the Benefit Payment Accuracy Review is to identify potential opportunities for recovery and/or cost savings associated with incorrect adjudication of plan design provisions.

TRICAST created an exact model of the benefit plan parameters of the State of Montana's pharmacy plan(s) in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified but could not be explained by TRICAST's benefit analysts were provided to MedImpact for explanation. If adequate documentation was provided to support that the exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Findings and Recommendations

The Benefit Payment Accuracy Review found that MedImpact's data didn't consistently provide identifiers within the data for patient level prior authorizations and all COB claims. Without these fields, TRICAST is unable to accurately calculate out-of-pocket (OOP) accumulators.

Our Benefit Payment Accuracy Review confirmed that with the exception of the above issue all prescription drug claims paid by MedImpact under the State of Montana's benefit plan(s) were paid correctly and in accord with the provisions in the plan sponsor's summary plan description(s) and plan documents.

HIPAA Compliance

TRICAST reviewed MedImpact's policies and procedures and found they demonstrate comprehensive control procedures, employee awareness and business protocols to maintain Protected Health Information (PHI) in compliance with the HIPAA standard.

Findings and Recommendations

MedImpact has implemented and is exercising best HIPAA practices.

Coordination of Benefits (COB) Verification

The analysis of State of Montana's COB claims revealed MedImpact is performing claim subrogation and coordination when a COB indicator is included in the claim file.

Opportunities for Improvement – None observed.

Performance Guarantees
Of the 39 total performance guarantees listed in the Service Agreement, 16 are measurable at the client, or individual group level (State of Montana - MTN01) while 23 are measured at the MAHCP level which TRICAST has no access to.
State of Montana MTN01 Level:

- 2014 and 2015: All 16 of the client or individual group level performance guarantees applicable to the State of Montana were met.

Opportunities for Improvement – None observed.

Fraud, Waste and Abuse (FWA)
TRICAST identified only five individuals with claims that had the potential of fraud, waste or abuse. When compared to other TRICAST clients of similar size, the number of cases and dollar amount involved were statistically insignificant.

Findings and Recommendations
MedImpact has reviewed all five members recommended by TRICAST and has sent these members to case management for further review and research.

MEDIMPACT'S RESPONSE TO DRAFT REPORT

MedImpact's response to our draft report is on the following page.

August 2, 2016

Re: #16007 State of Montana PBM Oversight Audit, Audit Report responses

Auditor Request:

Provide final responses to the Audit Report and the exceptions/issues identified by the auditor in this audit.

MedImpact Response:

Benefit Payment Accuracy Review

Copayments
Member Restrictions used to adjust copayment levels are determined solely by the State of Montana and are not driven off of any specific drug list – each Member override request is considered on an individual basis. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

Drug Exclusions/Prior Authorization
All drugs in the spreadsheet labeled "Exclusion and PA summaries, MI responses, vFINAL.xlsx" had a valid reason for coverage. Refer to that spreadsheet for detail.

Age Rules
Age edits for Zoster Vaccine, Foradil, and Serevent are coded to allowed coverage if the Member meets the age edit. A Prior Authorization is only required if members are under the age of 50 and 17 years for Zoster Vaccine and Foradil/Serevent, respectively. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

Quantity Limits
Quantity Limits were overridden by Plan exception. As such, these claims were paid correctly. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

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Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Medical Plans
Administered by Cigna

Audit Period: January 1, 2014 through December 31, 2015

Presented to

State of Montana

July 14, 2016

Presented by

Claim Technologies Incorporated
Known in Montana as CTI Claim Audit Technologies Corp.

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INTRODUCTION

This ***Specific Findings Report*** contains information, findings and conclusions from CTI's comprehensive audit of Cigna's claim administration of the State's plans. The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. This ***Specific Findings Report*** is provided to the State, the plan sponsor and Cigna, the claim administrator. Cigna's response to these findings is included with this report.

The information in this report is confidential and intended for the sole use of the Montana legislature, the State of Montana, Cigna and CTI in their efforts to serve the interests of the plan participants of the State of Montana Medical Plans. All findings are based on the data and information provided to CTI by Cigna and the State. Therefore, the validity of the findings relies heavily upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to contract terms between Cigna and the State as well as the approved benefit descriptions (summary plan descriptions, plan documents or other communications).

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the State's paid claims during the audit period.

Audit Objectives

The specific objectives of CTI's Comprehensive Audit of Cigna claims administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for the administrative services between the plan sponsor and claim administrator were followed;
- Determine whether claims were paid according to the provisions of the summary plan description (SPD) and the terms of the SPD were clear and consistent;
- Determine whether members were eligible and covered by the sponsor's medical plans at the time a service paid by Cigna was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a Comprehensive Audit of Cigna's claim administration of the State's medical plans. The random sample audit component included the 14-month period of January 1, 2015 through February 29, 2016. The population of claims and amount paid during the audit period were:

Total Paid Amount	$131,865,937
Total Number of Claims Paid/Denied/Adjusted	426,404

The audit included the components described below; the objective, scope, methodology and findings of each component are in the following sections of this report.

1. **Operational Review**
   - Operational Review Questionnaire
     - Claim administrator information
     - Claim administrator claim fund account
     - Claim adjudication and eligibility maintenance procedures
     - HIPAA compliance

2. **Plan Documentation Review**
   - Summary plan descriptions and/or plan documents
   - Administrative services agreement
   - Review, identification and resolution of ambiguities and inconsistencies

3. **100% Electronic Screening With Targeted Samples (ESAS®)**
   - Systematic analysis of 100% of paid services
   - 30 Targeted samples
   - Problem identification and quantification

4. **Random Sample Audit of 180 Claims**
   - Statistical confidence at 95% +/- 3%
   - Performance level determined for Key Indicators
   - Benchmarking
   - Problem identification and prioritization
   - Recommendations

5. **Data Analytics**
   - Systematic claims analysis for:
     - Provider Discount Review
     - Preventive Services Compliance Review
     - National Correct Coding Review

OPERATIONAL REVIEW

OPERATIONAL REVIEW

Objective

The objective of the operational review was to evaluate the systems, staffing, and procedures specifically related to Cigna's claim administration of the State plans and to observe any deficiencies that might materially affect their ability to control risk and accurately pay claims on behalf of the plans.

Scope

The scope of the operational review included the following:

- Claim administrator information
  - Insurance and bonding of the claim administrator
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Security of data and systems
  - Staffing
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service and eligibility maintenance procedures
  - Exception claims processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Customer service call and inquiry handling
  - Network utilization
  - Utilization review, case management and disease management
  - Appeals processing
- HIPAA compliance

Methodology

CTI gathered operational information from Cigna through the use of an operational review questionnaire. The questionnaire is modeled after the audit tool used by CPA firms when conducting an SSAE-16 audit of a service administrator. We have modified that tool to obtain information specific to the administration of the State's plans.

Through review of the responses and the supporting documentation given to us by Cigna, we gained an understanding of the procedures, staffing and systems that related to the administration of the State's plans. This understanding allowed us to be more effective while conducting this

audit. To the extent that we noted any uniqueness regarding the systems, staffing, and procedures that indicated a best-in-practice or improvement potential, we describe them in this section.

In addition to the operational review questionnaire, CTI utilized its proprietary ESAS® software to identify candidate cases to test certain operational processes. We selected a targeted sample of 30 candidate cases and distributed a substantive testing questionnaire to collect information on each. Responses were used to validate that procedures were being followed to control risk and accurately pay claims on behalf of the plans.

A complete list of the ESAS screening categories and subcategories used to identify candidate cases for operational review testing is shown in the following chart.

ESAS® Screening Categories and Subsets for Operational Review
Duplicate Payments to Providers and/or Employees
Duplicates within same claim
Fraud, Waste and Abuse
Large payments direct to employees Unnecessary nerve conduction studies Invalid procedure codes Gender specific
Subrogation/Right of Recovery from Third Party
Accidents and injuries
Workers' Compensation
Potential workers' compensation
Coordination of Benefits
Paid primary should be secondary to other group insurance Active employee, over 65; plan should be primary to Medicare Retired employee, plan should be secondary to Medicare
Denial of Mandated Benefits
Should not have denied – suicide Should not deny reconstructive surgery after cancer (WHCRA)
Large Claim Review
Claimants over $100,000
Case Management
Diagnosis specific Hemophilia/blood products
Provider Discounts and Fees
In-network discounts vs. usual reasonable and customary (URC) Non-network (secondary discounts) vs. URC Non-network (no discounts) vs. URC In-network provider but no discount taken Non-network provider with incorrect copayment
Dependent Child Eligibility
Payments for ineligible grandchildren Payments for over age dependents

Findings

Below are our findings relative to the operational review including:

- Operational review questionnaire
- ESAS and targeted samples of administrative procedures

Findings from Operational Review Questionnaire

A copy of the administrator's responses to the operational review questionnaire is provided under separate cover in the work papers that accompany this report.

Claim Administrator Information

CTI reviewed basic information about Cigna including background information, financial reports, types and levels of insurance protection, dedicated staffing, systems and software, disclosure of fees and commissions, performance standards and internal audit practices. From our review we offer the following observations:

- Cigna furnished a copy of its Service Organization Controls (SOC) Type 1 report for the period October 1, 2014 through September 30, 2015. In this report, Cigna provided a description of its claims processing system and system of internal controls which the service auditor validates. The administrator's external auditor, PricewaterhouseCoopers LLP, did not note any material deviations in Cigna's internal controls through testing performed. PricewaterhouseCoopers further noted that Cigna's control objectives, if operating effectively, were suitably designed to achieve the desired control objectives.
- Cigna declined to provide copies of certificates of liability for fidelity bond, errors and omissions, and cyber liability. Cigna did provide a summary of its Network Liability (Cyber Risk) insurance describing who is covered and separate components of coverage (privacy, data breach, advertising or electronic content infringement, reimbursement for customer notification and credit monitoring costs). CTI observes that few other administrators we have audited have provided this kind of summary for their clients. In light of publicity regarding recent data breaches affecting other companies, obtaining cyber liability coverage is an important issue for the State.
- Cigna provided a copy of its self-reported performance against contractual guarantees for calendar year 2015. Cigna did not attain the required goal for timeliness of medical claims processing, which is 96% within 14 calendar days. The penalty associated with this performance guarantee is $.32 per employee per month. The State should ensure that Cigna has paid this amount due. In addition, CTI notes that the contractual guarantee for financial accuracy of medical claims processing is measured at the "office" level (meaning for all claims processed at the same service center that handles the State's claims). CTI's independent audit of Cigna's performance indicates that financial accuracy for the State's claims alone was not met. Cigna's contract with the State also includes performance guarantees for provider rates. CTI's independent validation of discounts showed that Cigna's discount rates exceeded the guarantee of 20%.

Claim Funding

CTI reviewed information specific to controls and procedures related to claim checks including claim funding, fund reconciliation, handling of refunds and returned checks, large check approval, security, disposition of stale checks and appropriate audit trail reports, and COBRA and retiree/direct pay premium collection. From our review we offer the following observations:

- Cigna used appropriate levels of security and control within its claim funding and check issuance procedures to protect the plan's interest and ensure all transactions were performed by authorized personnel only. Only network operations/provider data management staff is authorized to add a provider or change provider management screens and claims processing and customer service personnel can view, but not update, eligibility information.
- Cigna has robust procedures to ensure physical security at its offices. Staff access to its facility, work area within the facility and workstations are limited to appropriate staff and passwords are changed at regular intervals. Data centers are not identified as Cigna buildings.

Claim Adjudication, Customer Service and Eligibility Maintenance Procedures

CTI reviewed information specific to the controls and procedures used by Cigna related to enrollment, eligibility maintenance and processing of claims. From our review we offer the following observations:

- Cigna had adequately documented training, workflow, procedures and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.
- More than 91% of claims submitted were electronic. This high rate of electronic submission typically increases the accuracy of claim payment and improves claim turnaround time.
- Cigna does not automatically recoup overpayments, but rather relies on a manual process for requesting return of an overpayment. Cigna does not recoup any claim payment of $10 or less. While this amount is typical for the industry, CTI notes that it is also very common for the recoupment process to be automated and overpayments pursued regardless of dollar amount.
- Cigna furnished an overpayment recovery report for the period January 2015 through February 2016. The State should ensure that it continues to monitor overpayment recovery until all open claims have been recovered or closed.
- Cigna furnished appeals reports for calendar year 2015 and for the period January 1, 2016 through May 31, 2016. Of the 210 appeals (both administrative and medical) filed in 2015, only 19% were overturned. CTI notes, however, that Level 1 medical appeals constitute 36.7% of total appeals volume. This is the second highest type of appeal, after Level 1 administrative appeals. Thirty-one of 77 appeals were overturned when providers not associated with the original case reviewed records on appeal. Similarly, in 2016, 23.2% of all appeals were overturned. However, 12 of 28 Level 1 administrative appeals included in the 2016 report or 42.9% of the 28 appeals filed, were overturned on appeal. The State should ask Cigna what led to the high percentage of appeals where original medical

decisions were overturned and how this information is relayed to staff making the original coverage decision.

- Cigna has a central unit for investigation of potential fraud in its office in Bloomfield, CT. Cigna recognizes that health care fraud impacts both the cost and quality of medical coverage by increasing the cost of doing business and creating a loss of public confidence. CTI observes that the fraud reporting provided by Cigna is better than we see from other administrators and that Cigna denied $232,579 in fraudulent claims during calendar year 2015 in the categories of misrepresentation of services, not medically necessary services, fee forgiveness and unnecessary services.

HIPAA Compliance

CTI reviewed information specific to the systems and processes Cigna had in place to maintain compliance with HIPAA regulations. The objective of this line of questioning was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. From our review we offer the following observation(s):

- Cigna had appropriate levels of security and controls in place to protect the State's medical plans records and data and was compliant with HIPAA requirements at the time of the audit.
- All Cigna associates must sign Cigna's Code of Ethics and Compliance which includes Cigna's Information Protection policy. Each functional unit must implement information protection awareness programs and must provide all users with the opportunity to receive training and information protection.

Findings from ESAS and Targeted Samples of Administrative Procedures

The following ***ESAS Summary Report*** shows, by category, the number of line items or claims and the total identified potential amount at risk. If process improvements opportunities were identified through this review, a detailed explanation of our findings and recommendations follows the ***ESAS Summary Report***.

We tested Cigna's controls and procedures by selecting specific claim cases processed during the audit period. Substantive testing questionnaires were prepared for each and sent to the administrator for completion. A CTI auditor reviewed the responses and supporting documentation.

ESAS Summary Report

Client: MTCigna16
Screening Period: 01/01/2014 - 02/29/2016

Analysis Final Results

Claims Red Flagged	145,747
Claimants Red Flagged	16,221
Paid Amount Red Flagged	$114,615,095
Potential Amount at Risk:	$5,038,692

Category	Lines	Clmts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP1C	534	196	Duplicate Payments to Providers and/or Employees	$116,688	$201,575 *	$84,888	
Fraud, Waste, and Abuse							
NCST	111	91	Unnecessary Nerve Conduction Studies	$29,704	$10,250		
GENx	4	3	Gender Specific	$878	$458		
Subrogation/Right of Recovery from Third Party							
SBxx	84917	8766	Subrogation/Right of Recovery from Third Party	$28,306,537	$14,465,483		
Workers' Compensation							
WCxx	9969	1239	Workers' Compensation	$4,836,739	$2,459,393		Yes
Coordination of Benefits							
MCRP	134139	2644	Retired Employee, Plan Should be Secondary to Medicare	$47,550,409	$14,007,527		
Denial of Mandated Benefits							
DE01	5	4	Denied, Possible Self-Inflicted Injury	$567	$0	($567)	
DE02	12	7	Denied, Reconstruction	$33,181	$0	($33,181)	
Large Claim Review							
CMLG	197128	343	Claimants over $100,000	$118,055,417	$81,617,946		
Case Management							
CMxx	31442	2710	Case Management	$14,254,311	$7,911,872		
Provider Discounts and Fees							
UI80	15912	6730	In-Network UCR at 80th, at 0.00 tolerance	$12,849,432	$7,425,347	$4,922,782	Yes
UO80	47	26	Out-of-Network UCR at 80th, at 0.00 tolerance	$75,101	$69,380	$64,770	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

Workers' Compensation

***Objective*:** Identify services at the line-item level that should be investigated for potential Workers' Compensation prior to payment. Look for procedural deficiencies in the administrative process to conservatively quantify additional costs caused by payment of expenses without thorough investigation to substantiate the appropriateness of a questionable service.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed that Cigna may have potentially overpaid certain service lines as a result of paying for services that should have been further investigated for Workers' Compensation.

Our analysis of the flagged service lines confirmed the potential for process improvement and the overpayment of claims proved to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) numbers 20 - 21 were sent to Cigna. A copy of their response is in the work papers. The results are shown on the following report entitled ***Substantive Testing Detail Report – Workers' Compensation,*** and confirm the potential for process improvement and overpayment of claims.

Recommendation(s)

In the category of Workers' Compensation – after removal of any cases that Cigna was able to document as not overpaid – we recommend continued monitoring and review of internal controls to ensure that system edits and manual overrides to system edits are monitored for accuracy and frequency.

Potential Recovery Amount	Number of Claimants	Recommendation(s)
$2,459,393	1,239	***Additional Observation:*** The State should talk with Cigna regarding a focused audit to determine recovery potential on these service lines and whether system edits could be refined to allow for better control against claim payments that may be related to Workers' Compensation.

Substantive Testing Detail Report – Workers' Compensation

Questionnaire ID Numbers: 20 - 21 (See Comprehensive Audit work papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Cigna Response
20	WCxx	Workers' Compensation	$0.00	Disagree. Treatment was the result of an incident that occurred at home.
21	WCxx	Workers' Compensation	$0.00	Disagree. The associated diagnosis codes are not investigated for subrogation.

Provider Discounts and Fees

Objectives: Identify claims in which the allowance may be greater than a geographical usual and customary allowance for both in-and out-of-network providers. We also validate that network provider payments conform to contracted terms, identify procedural deficiencies in the administrative process and conservatively quantify the additional cost to a plan caused by not processing claim in accordance with contract provisions.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed services where the allowances on in- and out- of network claims seemed high. The category with questionable pricing of service:

- In-network services where the allowed amount was greater than what would have been allowed if the claim was processed using a typical usual, customary and reasonable (UCR) database at the 80th percentile.

Substantive Testing

Substantive Testing Questionnaire (QID) number 26 was sent to Cigna. The results of the Substantive Testing are shown in the following report entitled Substantive Testing Detail Report Provider Discounts and Fees. The results indicate the potential for process improvement.

Recommendation

Provider Discounts and Fees Subcategory	Paid Claim Amount	Number of Claimants	Recovery/Process Improvement Opportunity
In-network vs. UCR at 80th percentile	$4,922,782	6,730	***Additional Observation:*** The State should discuss the improvement and savings potential of improved network provider pricing as well as better controls over the determination of allowable expense on in-network provider services with Cigna.

Substantive Testing Detail Report – Provider Discounts and Fees

Questionnaire ID Number: 19 (See Comprehensive Audit work papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Cigna Response
26	UI80	In-network UCR at 80th	$0.00	Disagree. Air ambulances were approved.

PLAN DOCUMENTATION REVIEW

PLAN DOCUMENTATION REVIEW

Objectives

The objective of the plan documentation review was to evaluate the documents governing the administration of the State's medical plans and identify any inconsistencies or ambiguities that might negatively impact accurate claim administration. Through this evaluation of documents we gained an understanding of the benefit plans and Cigna's administrative service responsibilities that related to claim administration of the State's medical plans. This understanding allowed us to be more effective throughout the audit. To the extent we noted issues within the plan documentation we describe them in this section.

Scope

Our auditors evaluated the following:

- Plan documents/summary plan descriptions and all amendments
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from the State and/or Cigna. Our auditors reviewed the applicable plan document and summary plan description (SPD) very closely as these documents describe the benefit plan provisions the claim administrator should be using to adjudicate all medical claims for Cigna. To assist them in understanding those provisions they used a tool we developed for this purpose called a benefit matrix. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions and limitations we expect to see in a plan document or SPD. When completed, the matrix allows us to identify inconsistencies and missing provisions. A copy of the benefit matrix for each plan we audited on behalf of the State has been provided in the work papers that accompany this report.

CTI obtained clarification from the State regarding any inconsistencies or missing provisions in the plan documents/SPDs. The benefit matrix was then used by our auditors as a cross reference tool as they audited claims.

Findings

Inconsistencies or missing provisions in the SPD or plan documents are referred to as gray areas by CTI. To the extent we observed any gray areas during this audit, we have included them here.

Inconsistencies Identified:

After review of the plan documents, and as observed through the course of ESAS (see CTI QID #9), plan document language on the exclusion of hearing aids found on pages 58 and 77, item 12 of the 2013 SPD should be reviewed to specifically state which parts of hearings aids are not covered. Cigna paid the related ear mold/insert as plan language does not specifically state it is not covered. Current plan language states: "vision examinations (may be covered under a separate vision exam plan described in II.D.1), orthoptics, vision training, hearing examinations, corrective appliances, and laser eye surgery. Corrective appliances include glasses, contact lenses, and hearing aids."

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES (ESAS®)

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES (ESAS®)

Objective

The objective of ESAS with targeted sampling was to identify and quantify potential claim administration payment errors. If over- or under-payments were identified and subsequently verified, the State and Cigna can work together to determine appropriate correct action.

Scope

CTI electronically screened 100% of the service lines processed by Cigna during the audit period plus the prior 12 months. During that period the administrator processed 826,957 claims (including adjustments) for 35,159 of the State's claimants representing 2,032,856 separate service line items and resulting in $253,928,374 in payment by the plans. CTI screened claims in up to 45 different categories and applied more than 400 unique algorithms when electronically screening this claim data. The accuracy and completeness of the claim data we were provided by the administrator directly impacts which screening categories we were able to run and the integrity of our findings. Following is a high level summary of the ESAS screening categories and subcategories for which we screened:

Summary of ESAS® Screening Categories to Identify Potential Amounts at Risk
Duplicate Payments to Providers and/or Employees
Duplicates from two claims
Duplicates from three or more claims
Plan Limitations
Specific to plan provisions such as: • Dollar limitations • Number of visit limitations
Payments after timely filing limit
Plan Exclusions
Specific to plan provisions such as: • Hearing aids • Cosmetic surgery • Weight loss treatment • Dental • Nutritional counseling
Multiple Surgical Procedures
Multiple procedures should have a reduced fee allowance

Methodology

The specific procedures followed to complete our ESAS with targeted sampling process of claim data for the State were as follows:

- *Electronic Screening Parameters Set* – We relied upon the plan provisions of the State's medical plan SPDs to set the parameters in our electronic screening system.
- *Data Conversion* – We converted and validated the claim data provided by Cigna. The converted data was reconciled against control totals and checked for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed by Cigna. Claims that were not processed in accordance with the parameters of the plans were flagged.
- *Auditor Analysis* – If flagged claims within an ESAS screening category represented material amounts, our auditors analyzed the category findings to confirm that the findings were valid. When using electronic screening to identify payment errors in claims, false positives occurred because certain claim data was misleading or inadequate. CTI auditors make every effort through the analysis to identify and remove false positives.
- *Targeted Samples* – From the categories where material amounts were identified, CTI auditors selected the best examples of potential over- or under-payments to test. These cases were not randomly selected therefore no extrapolation of the test results could be made. For this audit, a total of 30 flagged cases were selected. For each case a substantive testing questionnaire was prepared and sent to Cigna for completion. Targeted samples served to verify if the claim data provided by the administrator supported our electronic screening; and, if our understanding of the plan provision governing how that service should be adjudicated matches that of Cigna.
- *Audit of Administrator Response and Documentation* – A CTI auditor reviewed the substantive testing questionnaire responses. Copies of Cigna's responses to the questionnaires are included in the work papers that accompany this report. Please note that questionnaire responses presented in the work papers have been redacted to eliminate personal health information. Based on the responses from Cigna and further analysis of the ESAS findings in light of those responses, we removed any false positives that could be systematically identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the results represent *potential* payment errors and process improvement opportunities. Additional testing of these claims would be required to substantiate the findings and to provide the basis for remedial action planning or reimbursement.

Additionally, CTI was and is not authorized to tell Cigna to recover overpaid amounts. The process and impact of recovering overpayments must be discussed by the State and the administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures are improved to eliminate similar payment errors going forward.

The following ***ESAS Summary Report*** shows, by category, the number of line items or claims and the total potential amount at risk that remains at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the ***ESAS Summary Report*** is a detailed explanation of our substantive testing results, findings and recommendations for any screening category where it is our opinion that process improvement(s) or recovery/savings opportunities exist.

Please Note: If CTI is making an improvement recommendation, it will be denoted by a **Yes** in the right hand column of the ***ESAS Summary Report***.

ESAS Summary Report

Client: MTCigna16
Screening Period: 01/01/2014 - 02/29/2016

Analysis Final Results

Claims Red Flagged	5,971
Claimants Red Flagged	3,142
Paid Amount Red Flagged	$1,251,696
Potential Amount at Risk:	$842,557

Category	Lines	Clmts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP2A	68	18	Duplicate Payments to Providers and/or Employees	$7,851	$11,835 *	$3,984	
DP2B	586	165	Duplicate Payments to Providers and/or Employees	$29,507	$47,578 *	$18,071	
DP2C	1792	384	Duplicate Payments to Providers and/or Employees	$167,271	$278,850 *	$111,579	
DP2D	32	11	Duplicate Payments to Providers and/or Employees	$7,759	$13,692 *	$5,933	
DP3C	98	15	Duplicate Payments to Providers and/or Employees	$1,299	$5,832 *	$4,533	
Plan Limitations							
PL01	10	4	2014 Acupuncture and Chiro 20 visits combined	$500	$447 *	$447 *	
PL02	6	4	2015 Acupuncture and Chiro 20 visits combined	$279	$234 *	$233 *	
PL04	41	20	TMJ Non surgical not covered	$6,346	$5,776 *	$5,775 *	Yes
TFLM	1828	519	Timely Filing (Last service date to received date)	$593,904	$171,092	$171,092	Yes
Plan Exclusions							
EX07	3983	342	Automated Labs	$49,937	$38,016	$38,016	Yes
EX10	1	1	Custodial Care	$213	($60)	($60)	
EX12	244	172	Exercise Equipment	$2,216	$796	$796	
EX15	7	5	Hearing Exam	$623	$288	$288	
EX16	39	14	Hearing Aids & Supplies	$21,126	$15,353	$15,353	Yes
EX21	1	1	Radial Keratotomy	$250	$40	$40	
EX22	2	1	Vision Training (Orthoptics, Eye Exercises)	$139	$23	$23	
EX23	248	74	Routine Foot Care (OK Diabetic/Vascular Insufficiency)	$13,185	$1,739	$1,739	
EX24	183	121	Orthotics (Testing & Training)	$14,030	$5,200	$5,200	
EX25	369	267	Orthotics	$79,759	$33,762	$33,762	Yes
EX27	11	10	Orthopedic Shoes	$314	$73	$73	
EX28	230	9	Abortions, Elective	$9,520	$7,200	$7,200	Yes

EX32	36	16	Infertility Treatment	$6,149	$1,727	$1,727	
EX33	2	1	Reverse Elective Sterilization	$900	$174	$174	
EX38	360	134	Impotency	$41,486	$18,900	$18,900	Yes
EX40	5	3	Non-Emergency Transportation	$1,159	($143)	($143)	
EX53	12	4	Biofeedback	$830	$329	$329	
EX58	7	5	Educational Therapy & Supplies	$622	$269	$269	
EX59	59	18	Marriage Counseling	$5,112	$2,899	$2,899	
EX61	98	61	Nutritional Counseling (Non-diabetic)	$10,977	$9,815	$9,815	
EX63	641	313	Physicals, Work, Insurance, School	$45,475	$28,369	$28,369	
EX64	28	8	Massage Therapy	$1,289	$79	$79	
EX70	24	8	Weight Loss Surgical Treatment	$7,131	$5,096	$5,096	
EX71	1497	381	Weight Loss Treatment (non-surgical)	$186,595	$118,006	$118,006	
EXC2	11	2	Dermabrasion (acne scarring, wrinkle removal)	$2,509	$606	$606	
EXC4	27	10	Breast Reduction (Female, also Gynomastia in Males)	$65,425	$28,849	$28,849	
EXC5	1	1	Collagen Injections (Cosmetic)	$445	$284	$284	
EXC6	5	3	Cosmetic Surgery (Plastic-Excessive Skin Removal)	$2,656	$1,208	$1,208	
EXC8	32	17	Eye Surgery (Cosmetic) Blepharoplasty	$53,374	$21,163	$21,163	
EXC9	22	6	Face Recon. (Cosmetic/Genioplasty, Augmentation)	$79,977	$35,284	$35,284	
EXCC	2	1	Liposuction (Cosmetic)	$3,276	$1,044	$1,044	
EXCE	5	2	Nose Surgery--disguise plastic surgery as Med. Nec.	$17,227	$13,982	$13,982	
EXCF	261	75	Varicose Vein Treatment (sclerosing solutions)	$64,775	$5,350	$5,350	
EXCG	2	2	Tissue Expander (Cosmetic-not post mastectomy)	$9,422	$2,822	$2,822	
DX05	1	1	Dental, Testing and Laboratory	($656)	($418)	($418)	
DX14	10	1	Dental, Prosthodontics	$1,627	$63	$63	
Multiple Surgical Procedures							
MSPC	801	291	Multiple Surgical Procedures Should be Reduced Fee	$570,470	$376,096	$122,723	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

Plan Limitations

***Objective*:** Identify services that exceed plan limitations on quantity, frequency or benefit amount. We also identify procedural deficiencies in the administrative process and conservatively quantify the additional cost to the plan(s) caused by payments in excess of the plan(s) limitations.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines may have been overpaid as a result of exceeding the plan's limitations for coverage of:

- Timely filing of claims
- TMJ Non-surgical not covered

Additional analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) number(s) 5 - 7 were sent to Cigna. Copies of their response(s) are in the work papers. The results confirmed the potential for process improvement and overpayment of claims.

Recommendation(s)

In the category of Plan Limitations – after removal of any cases that Cigna was able to document as not overpaid – we recommend the following:

Limitation Subcategory	Potential Recovery Amount	Number of Claimants	Recommendation(s)
Timely Filing of Claims	$171,092	519	The State should talk with Cigna regarding a focused audit to determine recovery potential on these claims and discern if system edits could be refined to prevent paying claims that are specifically limited by the plans.
TMJ Non-surgical Not Covered	$5,775	20	

Substantive Testing Detail Report – Plan Limitations

Questionnaire ID Numbers: 5 - 7 (See Comprehensive Audit work papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Cigna Response
5	PL04	TMJ Non-surgical not covered	$1,722.32	Disagree. Claim was for a diagnostic MRI, no treatment was done.
6	TFLM	Timely Filing	$4,081.72	Disagree. Based on the timely filing SOP when COB involved, 2 years to process.
7	TFLM	Timely Filing	$921.96	Disagree. Provider sent the claim to wrong address, it was returned and resubmitted.

Plan Exclusions

***Objective*:** Identify services that should have been denied due to specific exclusions defined in the summary plan description (SPD) or plan document(s). We also identify procedural deficiencies in the administrative process and quantify conservatively the additional cost to a plan(s) caused by the payment of excluded expenses.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain services may have been overpaid as a result of paying for services that should have been denied due to exclusions defined in the SPD or plan document(s).

Additional analysis of the services flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) number(s) 8 – 12 were sent to Cigna. Copies of their response(s) are in the work papers. The results are shown in the following report entitled ***Substantive Testing Detail Report – Plan Exclusions***.

Recommendation(s)

In the category of Plan Exclusions – after removal of any cases that Cigna was able to document as not overpaid – we recommend the following:

Exclusion Subcategory	Potential Recovery Amount	Number of Claimants	Recommendation(s)
Orthotics	$33,762	267	The State should talk with Cigna regarding a focused audit to determine recovery potential on these claims and discern if system edits could be refined to prevent paying claims that are specifically excluded by the plans.
Impotency	$18,900	134	
Abortions, Elective	$7,200	9	

Exclusion Subcategory	Paid Claim Amount	Number of Claimants	Recommendation(s)
TC/26 Modifier Usage	$38,016	342	***Additional Observation:*** The State should talk with Cigna regarding a focused audit to determine recovery potential on these claims and discern if system edits could be refined to prevent paying claims that are specifically excluded by the plans.
Hearing Aids & Supplies	$15,353	14	

Substantive Testing Detail Report – Plan Exclusions

Questionnaire ID Numbers: 8 - 12 (See Comprehensive Audit work papers – Substantive Testing Questionnaire Responses)

QID No:	Flag Type	Flag Description	Overpaid Amt	Cigna Response
8	EX07	TC 26 Modifier Usage	$0.00	Disagree. Claim Check follows the American Medical Association guidelines.
9	EX16	Hearing Aids & Supplies	$0.00	Disagree. Code billed is for the ear mold/insert, not the actual hearing aid.
10	EX25	Orthotics	$500.00	Agree.
11	EX28	Abortions, Elective	$513.75	Agree.
12	EX38	Impotency	$252.89	Disagree. Claim is an office visit, not "treatment of sexual inadequacy or dysfunction".

RANDOM SAMPLE AUDIT

RANDOM SAMPLE AUDIT

Objectives

The objectives of our random sample audit were to determine that claims were paid in accordance with plan specifications and the administrative agreement, to measure and benchmark administrative process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

The scope of our random sample audit included the audit of a stratified random sample of 180 paid or denied claims. The claims were audited at Cigna's claim processing facility in Denison, TX. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the ***Sample Construction and Weighting Methodology Report*** for this audit sample is provided in Appendix A.

The administrator's performance was measured using Key Performance Indicators as follows:

- Financial Accuracy Rate
- Accurate Payment Frequency
- Accurate Processing Frequency
- Adjudication Proficiency
- Documentation Accuracy – Financial
- Documentation Accuracy – Frequency

We also measured claim turnaround time, which is a commonly relied upon measurement of claim administration performance.

Our auditors may have also made additional observations regarding processes or payments that went beyond the scope of our random sample audit. If so, those observations are reflected in this section of the report.

Methodology

Each sample claim selected was reviewed to ensure it conformed to the plan specifications, agreements, and negotiated discounts. Findings were recorded in CTI's proprietary audit system.

When applicable, errors were cited if a claim selected in the random sample was paid or processed incorrectly based on member eligibility or plan provisions as defined in the SPD(s) or amendments. Payment errors were observed based on the way the selected claim was paid and the information Cigna had at the time the transaction was processed. If the sampled claim was subsequently corrected, the error was still cited to allow for root cause analysis to avoid recurrence of the error.

CTI communicated with the administrator about any errors or observations in writing using system generated observation response forms. Copies of the error or additional observation forms remaining after CTI's final review are included in the work papers accompanying this report.

A preliminary ***Random Sample Audit Report*** was sent to Cigna for review and response in writing. Cigna response was considered when producing the final ***Specific Findings Report*** and is provided in Appendix B. Ultimately, the payment and procedural errors remaining were accumulated and used to determine results for each Key Performance Indicator. Definitions of the Key Performance Indicators are provided in this section along with their respective results.

Moving forward, the process and impact of improving processes and adjusting payment errors identified through this random sample audit should be discussed between the State and Cigna.

Findings

Performance, as measured by the random sample audit for each Key Performance Indicator, is presented in the pages immediately following.

Financial Accuracy Rate

***Operational Definition*:** The total correct claim payments that were made compared to the total dollars of correct claim payments that should have been made for the audit sample. The formula for this measure is: *Total correct payments (claims paid in the sample minus overpayments plus underpayments) minus the absolute variance (overpayments plus underpayments) divided by total correct payments.*

Claims sampled and reviewed by CTI revealed $15,434 in underpayments and $1,080 in overpayments, for a combined variance of $16,513.

The correct payment total for the adequately documented claims in the audit sample should have been $400,926. Note that CTI only uses adequately documented claims for this calculation.

- Financial accuracy rate for the claims sampled for this audit period was 95.88%.
- On a weighted, adjusted basis for the audit universe financial accuracy rate was 96.76**%.**

Each error found in the random sample audit is listed in the following error detail report titled ***Financial Accuracy Rate and Accurate Payment Frequency***.

Error Detail Report: Financial Accuracy Rate and Accurate Payment Frequency

Audit Numbers: 1001 - 1180

Primary Cause	Indicator Description / CTI AuditNo.	Claim No.	Entered Amount	Correct Amount	Under Paid	Over Paid	Cigna Response
COP	Co-pay calculation error						
	1081	9671507996737-	$877.38	$885.83	($8.45)	$0.00	Disagree
	Subtotal: 1		$877.38	$885.83	($8.45)	$0.00	
DEE	Denied eligible expense						
	1005	4671500294154-	$0.00	$14,100.73	($14,100.73)	$0.00	Agree
	Subtotal: 1		$0.00	$14,100.73	($14,100.73)	$0.00	
MCI	Incorrect COB with Medicare						
	1141	7671530190435-	$351.03	$390.93	($39.90)	$0.00	Agree
	1146	8671517094921-	$349.90	$357.27	($7.37)	$0.00	Agree
	1152	8671518791215-	$681.97	$742.48	($60.51)	$0.00	Agree
	1172	8671436592773-	$3,205.79	$3,206.45	($0.66)	$0.00	Agree
	1173	4671508693017-	$340.06	$380.92	($40.86)	$0.00	Agree
	Subtotal: 5		$4,928.75	$5,078.05	($149.30)	$0.00	
PIP	Paid ineligible procedure (not previously cited)						
	1134	9671526697596-	$512.50	$142.50	$0.00	$370.00	Disagree
	Subtotal: 1		$512.50	$142.50	$0.00	$370.00	
PPNP	Paid PPO provider as Non-PPO Provider						
	1025	9671505590871-	$132.23	$864.10	($731.87)	$0.00	Agree
	Subtotal: 1		$132.23	$864.10	($731.87)	$0.00	
PPO	PPO discount calculation error						
	1001	7671331091857-	$1,105.66	$1,040.23	$0.00	$65.43	Agree
	1056	8671514296602-	$3,834.94	$4,278.46	($443.52)	$0.00	Agree
	1072	9671524096825-	$4,602.82	$4,602.81	$0.00	$0.01	Agree
	1108	4671526894505-	$15.00	$14.70	$0.00	$0.30	Agree
	Subtotal: 4		$9,558.42	$9,936.20	($443.52)	$65.74	
TF	Charges were paid after the time limit specified in the plan						
	1007	0671502817002-	$643.84	$0.00	$0.00	$643.84	Disagree
	Subtotal: 1		$643.84	$0.00	$0.00	$643.84	
Total Number of Claims: 14					($15,433.87)	$1,079.58	

Accurate Payment Frequency

***Operational Definition*:** The number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 14 incorrectly paid claims and 166 correctly paid claims.

The incorrectly paid claims were comprised of 9 underpaid claims and 5 overpaid claims. Note that CTI only uses adequately documented claims for this calculation.

Accurate payment frequency for the claims sampled was 92.22%.

Each error found in the random sample audit is listed in the error detail report shown in the preceding report titled ***Financial Accuracy Rate and Accurate Payment Frequency***.

Accurate Processing Frequency

***Operational Definition*:** The number of claims processed without errors compared to the total number of claims processed in the audit sample.

When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

The audit sample revealed 166 claims processed without any type of error, while 14 claims had one or more errors.

Accurate processing frequency for the sample and all claims processed during the audit period was 92.22%.

There is no error detail report for this performance indicator since the specific errors are referenced in respect to other measures in this report.

Adjudication Proficiency

***Operational Definition*:** The number of correct adjudication decisions made compared to the total number of adjudication decisions required for the claims within the audit sample.

There were 1,931 separate decisions reviewed during the audit period and an average of 10.7 decisions for each claim was reviewed to determine adjudication proficiency. 14 adjudication errors were observed in the audit sample.

Adjudication proficiency for the claims sampled and all claims in the universe was 99.27%.

The adjudication errors found in the random sample audit are in the following ***Adjudication Proficiency*** error detail report. Adjudication errors can result in payment errors and/or may have been the result of inadequate documentation. To the extent that this has occurred, the same CTI audit numbers may appear on more than one report.

Error Detail Report: Adjudication Proficiency

Audit Numbers: 1001 - 1180

Error Type	Question Description	Indicator	Indicator Description	Examiner Flag	CTI Audit	LineNo.	Cigna Response
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1141		Agree
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1146		Agree
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1152		Agree
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1172		Agree
ADJUD	COB Adjud	MCI	Incorrect COB with Medicare		1173		Agree
	5 COB Adjud						
ADJUD	Managed Care	COP	Co-pay calculation error		1081	001	Disagree
ADJUD	Managed Care	PPNP	Paid PPO provider as Non-PPO Provider		1025	001	Agree
	2 Managed Care						
ADJUD	Timely Filing	TF	Charges were paid after the time limit specified in the plan		1007		Disagree
	1 Timely Filing						
ADJUD	Policy Provisions	DEE	Denied eligible expense		1005	001	Agree
ADJUD	Policy Provisions	PIP	Paid ineligible procedure (not previously cited)		1134	002	Disagree
ADJUD	Policy Provisions	PPO	PPO discount calculation error		1001	001	Agree
ADJUD	Policy Provisions	PPO	PPO discount calculation error		1056	002	Agree
ADJUD	Policy Provisions	PPO	PPO discount calculation error		1072	006	Agree
ADJUD	Policy Provisions	PPO	PPO discount calculation error		1108	001	Agree
	6 Policy Provisions						

Examiner Error:	14
System Error:	0
Total Count:	14

Documentation Accuracy – Financial

***Operational Definition*:** The dollar amounts processed with documentation adequate to substantiate payment or denial compared to the dollar amounts processed in the audit sample.

The audit sample revealed the documentation needed to support all payments was present.

Documentation accuracy – financial for the claims sampled for this audit period was 100%.

On a weighted, adjusted basis for the audit universe documentation accuracy – financial was 100%.

Documentation Accuracy – Frequency

***Operational Definition*:** The number of claims processed with documentation adequate to substantiate payment or denial compared to the total number of claims processed in the audit sample.

The audit sample revealed no inadequately documented payments.

Documentation accuracy – frequency for the audit sample was 100%.

Claim Turnaround

***Operational Definition*:** The number of calendar days required to process a claim – from the date the claim is received by the administrator to the date a payment, denial or additional information request is processed – expressed as both the Mean and Median for the audit sample.

Median claim turnaround time for the sample was 10 day(s) from *the date received by the claim administrator* to the *date the claim was processed*. 25 of the claims in the sample took 45 days or longer to process. Same day turnaround on claims is the fastest turnaround time that can be achieved – but it is not necessarily the best turnaround time. The administrator should balance claim turnaround by handling all types of claims as efficiently as possible.

A detailed claim turnaround analysis is in the following report titled ***Claim Turnaround Analysis.***

NOTE: Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing claim turnaround because it prevents one or a few claims with extended turnaround time(s) from distorting the true performance picture. The mean claim turnaround from *date received* to *date processed* was 32 day(s).

Claims Turnaround Analysis – Paid and Pended

Audit Numbers: 1001 - 1180

Audit	Claim Number	Last Service	To	Date Signed	To	Date Complete Clm Rcvd by	To	Process Date	To	Date EOB/Ck Mailed	Total Days
		*Pended Claims Averages:	0		0		0		0		0
		Non-Pended Claims Averages:	17		28		32		1		78
		Combined Averages (Pended && Non-Pended):	17		28		32		1		78

Number of Days Between Received and Processed Dates:

1 Day.	0	26 Days.	1
2 Days.	46	27 Days.	2
3 Days.	7	28 Days.	0
4 Days.	3	29 Days.	0
5 Days.	2	30 Days.	1
6 Days.	4	31 Days.	0
7 Days.	3	32 Days.	0
8 Days.	14	33 Days.	1
9 Days.	10	34 Days.	0
10 Days.	6	35 Days.	0
11 Days.	3	36 Days.	1
12 Days.	4	37 Days.	0
13 Days.	5	38 Days.	0
14 Days.	6	39 Days.	1
15 Days.	7	40 Days.	0
16 Days.	6	41 Days.	0
17 Days.	2	42 Days.	1
18 Days.	2	43 Days.	0
19 Days.	4	44 Days.	2
20 Days.	6	45 Days	0
21 Days.	3	> 45 Days	25
22 Days.	0	Undetermined:	0
23 Days.	2	Total Number of Claims:	180
24 Days.	0		
25 Days.	0		

Days:
Median: 10

Additional Findings and Observations

During the course of the random sample audit, procedures or situations were observed that may not have caused an error on the sampled claim – but may have an impact on future claims or the overall quality of service. These additional observations are summarized in the following table. To view the observation response forms associated with these situations or observations, refer to the corresponding CTI audit number in the work papers that accompany this report.

Additional Observations	CTI Audit Number/Cigna Response
Per the claims data provided, this patient's out-of-pocket (OOP) accumulation is $5,004.42 and not the $5,000.00 reflected in the Cigna accumulations.	1005 Agree
CTI notes a deductible over-accumulation of $34.00 and OOP over-accumulation of $47.81. The State and Cigna should discuss the matter of adjusting this member's file.	1011 Agree
CTI notes an OOP over-accumulation of $100.00. The State and Cigna should discuss the matter of adjusting this member's file.	1015, 1043 Agree
CTI notes an OOP over-accumulation of $97.42. The State and Cigna should discuss the matter of adjusting this member's file.	1018 Agree
CTI notes an OOP over-accumulation of $400.00. The State and Cigna should discuss the matter of adjusting this member's file.	1022, 1036, 1068 Agree
CTI notes an OOP over-accumulation of $300.00. The State and Cigna should discuss the matter of adjusting this member's file.	1026 Agree
CTI notes an OOP over-accumulation of $200.00. The State and Cigna should discuss the matter of adjusting this member's file.	1031, 1039 Agree
CTI notes an OOP over-accumulation of $55.51. The State and Cigna should discuss the matter of adjusting this member's file.	1038 Agree
CTI notes an OOP over-accumulation of $2,911.70. The State and Cigna should discuss the matter of adjusting this member's file.	1054 Agree
CTI notes an OOP over-accumulation of $87.09. The State of Cigna should discuss the matter of adjusting this member's file.	1055 Agree
CTI notes an OOP over-accumulation of $3,300.91. The State and Cigna should discuss the matter of adjusting this member's file.	1057 Agree
CTI notes an OOP over-accumulation of $4.81. The State and Cigna should discuss the matter of adjusting this member's file.	1061 Agree
CTI notes a deductible over-accumulation of $376.37 and OOP over-accumulation of $100.00. The State and Cigna should discuss the matter of adjusting this member’s file.	1086 Agree

Additional Audit Results	
COB savings (unweighted)	23.44%*
Record retrieval capability – percent of claims selected for audit sample for which complete records were produced	100%**

*COB savings was calculated based on the audit sample using the claim dollars saved by the plans through coordination with other group plans and Medicare as a percentage of the correct total claim dollars paid. The random sample audit further showed that COB savings, if all claims had been coordinated correctly, would have been 23.30% of paid claims.

**180 claims initially were requested for the audit sample. The administrator provided documentation for all requested claims.

DATA ANALYTICS

DATA ANALYTICS

This component of the audit used the electronic claim data to provide additional meaningful information. The standard informational categories we analyzed the data for include:

- Network provider utilization and savings*;*
- Compliance with the Preventive Services Coverage requirement under the Patient Protection and Affordable Care Act; and
- Administrator claim system code editing capability as compared to the Centers for Medicare & Medicaid Services National Correct Coding Initiatives (NCCI).

Provider Utilization and Discount Savings

Objective

The objective of CTI's provider discount review was to provide the plan sponsor with an evaluation of their provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, CTI believes calculating discounts in the same manner for all of its audit clients allows for meaningful comparisons to be made.

Scope

CTI's ***Provider Utilization and Discount Savings Report*** compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three sub-sets:

- In-network;
- Out-of-network; and
- Secondary networks.

Each of the above mentioned sub-sets was further delineated into four sub-groups:

- Ancillary services;
- Non-facility services;
- Facility inpatient; and
- Facility outpatient.

Methodology

The following ***Provider Utilization and Discount Savings Report*** relied on the data provided by the administrator and only used the data fields provided with no assumptions made when necessary data fields were not provided by the administrator.

Findings

Provider Discount Review Paid Dates 01/01/2015 through 02/29/2016				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$9,637,475	$2,606,289	27.0%	$5,666,814
Non-Facility	$74,364,559	$21,421,324	28.8%	$40,085,090
Facility Inpatient	$54,004,213	$9,903,579	18.3%	$41,238,002
Facility Outpatient	$65,775,077	$11,684,412	17.8%	$44,876,031
Total	**$203,781,325**	**$45,615,603**	**22.4%**	**$131,865,937**
In-Network				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$7,478,163	$1,938,612	25.9%	$4,517,137
Non-Facility	$71,733,948	$20,552,826	28.7%	$39,551,743
Facility Inpatient	$52,739,369	$9,733,423	18.5%	$40,390,599
Facility Outpatient	$64,489,998	$11,083,283	17.2%	$44,442,503
Total In-Network	**$196,441,477**	**$43,308,145**	**22.0%**	**$128,901,982**
% of Allowed Charge -	96.4%	% Claim Frequency -	95.0%	
Out of Network				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$2,159,312	$667,677	30.9%	$1,149,677
Non-Facility	$2,630,612	$868,498	33.0%	$533,346
Facility Inpatient	$1,264,845	$170,156	13.5%	$847,403
Facility Outpatient	$1,285,079	$601,128	46.8%	$433,528
Total Out of Network	**$7,339,848**	**$2,307,459**	**31.4%**	**$2,963,954**
% of Allowed Charge -	3.6%	% Claim Frequency -	5.0%	
Secondary				
Claim Type	**Allowed Charge**	**Provider Discount**		**Paid**
Ancillary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Allowed Charge -	0.0%	% Claim Frequency -	0.0%	

Affordable Care Act Preventive Services Coverage Compliance

Objective

The objective of the preventive care services compliance review was to confirm that Cigna was processing preventive services as required by the Patient Protection and Affordable Care Act (PPACA) and as regulated by the Department of Health and Human Services (HHS). The federal

mandate under PPACA for all health plans (unless the plan is grandfathered as defined under PPACA) is that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance or deductible. Our review analyzes in-network preventive care services to determine whether or not those services were paid in compliance with the PPACA guidelines.

Scope

CTI's review included all in-network services that we believe should be categorized as preventive services and paid at 100%. The guidance provided by HHS allows individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI has researched best practices from many major health plan administrators and developed a compliance review we believe reflects the industry's most comprehensive view of procedures to be paid at 100%.

Our review ***did not*** include the following:

- Services performed by any out-of-network provider;
- Services with dates of service prior to January 1, 2013 (the federal requirement to cover preventive services became effective on the plan's first renewal date on or after August 1, 2012);
- Services adjusted or paid more than once (duplicate payments) during the audit period; and
- Services where PPACA requirements suggest a frequency limitation such as one per year.

Methodology

Our data analytics parameters relied upon the published recommendations from the sources that HHS used to create the list of preventive services for which it has mandated coverage. We also looked at best practices of health claim administrators to identify covered preventive services. We believe this reflects best practice in the health care insurance industry for payment of covered services as defined under PPACA.

Findings

We analyzed the payments to determine if they were compliant. Types of services on which non-compliance was identified (if any) are listed first and the percent of allowed charge paid are in the last column on the following chart. To demonstrate full compliance with PPACA's requirement for coverage of preventive services, the last column should show that 100% of these services performed by network providers were paid and that no deductible, coinsurance or copayment was applied.

Because services may be denied for a reason other than exclusion or limitation of non-covered services (e.g. a service could be denied because the patient was not eligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims being paid at less than required benefit levels. (i.e., claims that have a reduced payment due to the application of deductibles, coinsurance, and/or copayments). There were 78 categories of preventive services screened electronically as part of CTI's preventive services compliance review. These 78 categories match the preventive care services specified by the HHS including immunizations, women's health,

tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirmed compliance with PPACA preventive services coverage requirements, or pointed out the areas where improvements can be achieved.

The following report provides an outline for discussion between the State and Cigna. The claim detail supporting each finding can be provided upon request.

Preventive Care Services Compliance Review

Administrator: Cigna
Audit Range: 01/01/2015 - 02/29/2016
Plans: All
Filters: Exclude - out-of-network, adjustments, duplicates, edits with frequency limits

		Claims Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid in Full @ 100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-B	Abdominal aortic aneurysm screening - men	1	0	1	$372	0	$0	1	$6	0	$0	0.00%
USPSTF-A	Hemoglobinopathies or sickle cell screening	1	0	0	$0	0	$0	1	$2	0	$0	0.00%
USPSTF-B	BRCA screening counseling - women	170	7	0	$0	108	$2,145	1	$26	54	$8,166	31.76%
ACIP	Immunizations adult - Influenza Age (FluMi	3	2	0	$0	0	$0	0	$0	1	$30	33.33%
USPSTF-B	Hearing loss screening - 0 - 90 days	6	2	1	$30	0	$0	0	$0	3	$576	50.00%
USPSTF-B	Breast cancer chemoprevention counseling	47	1	0	$0	22	$440	0	$0	24	$4,110	51.06%
USPSTF-A	Hypothyroidism screening - 0-90 days	3	1	0	$0	0	$0	0	$0	2	$23	66.67%
USPSTF-B	Diabetes screening	15	0	4	$73	0	$0	0	$0	11	$172	73.33%
USPSTF-B	Hepatitis C Virus (HCV) Screening	23	1	3	$74	0	$0	2	$28	17	$287	73.91%
USPSTF-B	Vision screening - 3- 5	24	1	0	$0	5	$98	0	$0	18	$87	75.00%
USPSTF-B	Depression screening - >18	4	1	0	$0	0	$0	0	$0	3	$90	75.00%
USPSTF-B	Healthy diet counseling	37	8	0	$0	0	$0	0	$0	28	$2,695	75.68%
HHS	Gestational diabetes screening - women	229	6	25	$871	0	$0	24	$169	174	$1,980	75.98%
Bright Futures	Lead screening - <21	30	0	7	$119	0	$0	0	$0	23	$384	76.67%
USPSTF-B	Gonorrhea screening - women	271	9	36	$2,477	0	$0	15	$281	211	$11,686	77.86%
HHS	Contraceptive methods - women	1,295	45	0	$0	0	$0	238	$3,476	1,011	$275,235	78.07%
USPSTF-B	Obesity screening and counseling - >18	30	5	0	$0	0	$0	0	$0	24	$2,040	80.00%
HHS	Human papillomavirus DNA testing - wome	306	32	18	$1,168	0	$0	5	$91	251	$14,847	82.03%
ACIP	Immunizations - Human Papillomavirus 19-2	25	4	0	$0	0	$0	0	$0	21	$3,992	84.00%
Bright Futures	Tuberculin testing - <21	27	0	0	$0	4	$80	0	$0	23	$336	85.19%
ACIP	Immunizations - Hepatitis B >18	70	10	0	$0	0	$0	0	$0	60	$4,357	85.71%
ACIP	Immunizations - Meningococcal >18	21	3	0	$0	0	$0	0	$0	18	$2,189	85.71%
USPSTF-A,B	Cholesterol abnormalities screening - wom	203	15	9	$189	0	$0	2	$11	177	$5,571	87.19%
USPSTF-A	Tobacco use counseling - >18	40	1	1	$16	0	$0	3	$16	35	$814	87.50%
ACIP	Immunizations - Measles, Mumps, Rubella	46	5	0	$0	0	$0	0	$0	41	$2,849	89.13%
ACIP	Immunizations - Hepatitis A >18	111	12	0	$0	0	$0	0	$0	99	$6,268	89.19%
USPSTF-A	Syphilis screening - pregnant women	29	1	2	$14	0	$0	0	$0	26	$252	89.66%
ACIP	Immunizations - Influenza Age >18	1,612	163	0	$0	0	$0	0	$0	1,449	$23,837	89.89%
HHS	Wellness Examinations - >18	1,276	119	0	$0	0	$0	0	$0	1,152	$227,864	90.28%
USPSTF-A	Cervical cancer screening - women	1,725	148	2	$97	0	$0	1	$11	1,574	$70,477	91.25%
HHS	Wellness Examinations - women	5,834	351	0	$0	132	$2,723	2	$56	5,325	$960,223	91.28%
USPSTF-A,B	Chlamydia infection screening - women	310	18	7	$334	0	$0	1	$19	284	$16,756	91.61%
ACIP	Immunization Administration - >18	3,280	269	0	$0	0	$0	0	$0	3,011	$89,821	91.80%
USPSTF-A	Cholesterol abnormalities screening - men	346	21	4	$59	0	$0	0	$0	321	$7,211	92.77%
ACIP	Immunizations - Herpes Zoster >59	98	7	0	$0	0	$0	0	$0	91	$18,524	92.86%
USPSTF-A	HIV screening - >14	113	5	2	$41	0	$0	1	$3	105	$2,094	92.92%
ACIP	Immunizations - Influenza Age (FluZone) 65	62	4	0	$0	0	$0	0	$0	58	$2,065	93.55%
ACIP	Immunizations - Pneumococcal >18	393	25	0	$0	0	$0	0	$0	368	$56,248	93.64%
ACIP	Immunizations - Pneumococcal <19	862	54	0	$0	0	$0	0	$0	808	$148,578	93.74%
ACIP	Immunizations - Influenza <19	1,638	90	0	$0	0	$0	0	$0	1,548	$34,312	94.51%
Bright Futures	Dyslipidemia screening - 2-20	41	2	0	$0	0	$0	0	$0	39	$1,144	95.12%
HHS	Breastfeeding support and counseling - wor	187	2	0	$0	6	$115	1	$43	178	$38,284	95.19%
HRSA/HHS	Wellness Examinations - <19	3,637	154	0	$0	0	$0	0	$0	3,473	$565,641	95.49%
ACIP	Immunization Administration - <19	6,114	271	0	$0	0	$0	0	$0	5,843	$256,566	95.57%
Bright Futures	Iron Supplement - <21	246	7	3	$15	0	$0	0	$0	236	$1,261	95.93%
ACIP	Immunizations - Measles, Mumps, Rubella	475	19	0	$0	0	$0	0	$0	456	$48,469	96.00%
ACIP	Immunizations - Human papillomavirus	588	22	0	$0	0	$0	0	$0	566	$104,394	96.26%
USPSTF-A	Hepatis B screening - women	54	2	0	$0	0	$0	0	$0	52	$1,273	96.30%
ACIP	Immunizations - Rotavirus <19	522	18	0	$0	0	$0	0	$0	504	$52,319	96.55%
ACIP	Immunizations - Hepatitis B <19	59	2	0	$0	0	$0	0	$0	57	$1,693	96.61%
ACIP	Immunizations - DTP >18	847	27	0	$0	0	$0	0	$0	820	$32,297	96.81%
USPSTF-A	HIV screening - pregnant women	208	4	1	$5	0	$0	1	$3	202	$4,954	97.12%
AMA	Modifier 33	2,117	57	0	$0	1	$20	0	$0	2,059	$354,856	97.26%
USPSTF-A	Colorectal cancer screening - 50-75	1,168	28	0	$0	0	$0	0	$0	1,140	$526,015	97.60%
ACIP	Immunizations - Meningococcal <19	341	8	0	$0	0	$0	0	$0	333	$42,162	97.65%
ACIP	Immunizations - DTP <19	1,369	32	0	$0	0	$0	0	$0	1,337	$82,544	97.66%
ACIP	Immunizations - Haemophilus influenzae b	642	15	0	$0	0	$0	0	$0	627	$18,569	97.66%
USPSTF-B	Breast cancer mammography screening - >3	4,865	86	2	$61	0	$0	2	$27	4,775	$276,035	98.15%
ACIP	Immunizations - Hepatitis A <19	636	8	0	$0	0	$0	0	$0	628	$22,482	98.74%
Bright Futures	Developmental Autism screening - <3	271	3	0	$0	0	$0	0	$0	268	$4,121	98.89%
ACIP	Immunizations - Varicella <19	738	8	0	$0	0	$0	0	$0	730	$76,883	98.92%
USPSTF-A,B	Rh incompatibility screening - pregnant wor	58	0	0	$0	0	$0	0	$0	58	$552	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	40	0	0	$0	0	$0	0	$0	40	$1,360	100.00%

		Claims Sumbitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid in Full @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-B	Anemia screening - pregnant women	16	0	0	$0	0	$0	0	$0	16	$118	100.00%
USPSTF-A	Syphillis screening	16	0	0	$0	0	$0	0	$0	16	$95	100.00%
ACIP	Immunizations - Varicella >18	15	0	0	$0	0	$0	0	$0	15	$1,560	100.00%
USPSTF-B	Osteoporosis screening - women >64	12	0	0	$0	0	$0	0	$0	12	$343	100.00%
USPSTF-C	HIV screening - 14-18	5	0	0	$0	0	$0	0	$0	5	$112	100.00%
USPSTF-B	Alcohol misuse - screening and counseling	3	0	0	$0	0	$0	0	$0	3	$137	100.00%
USPSTF-B	Cholesterol abnormalities screening - men	2	0	0	$0	0	$0	0	$0	2	$61	100.00%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	1	0	0	$0	0	$0	0	$0	1	$11	100.00%
USPSTF-B	Depression screening - 12-18	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-B	Obesity screening and counseling - 6-18	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-B	Sexually transmitted infection screening - <	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-B	Sexually transmitted infections counsel wo	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-B	Sexually transmitted infections counseling	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-B	Tobacco use counseling - <19	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-A	Tobacco use counseling - pregnant women	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
USPSTF-A	Urinary tract infection screening - pregnant	0	0	0	$0	0	$0	0	$0	0	$0	100.00%
	Totals	45,909	2,221	128	$6,016	278	$5,621	301	$4,269	42,940	$4,523,355	93.53%

Correct Coding Review Objective; CMS Edits

The Centers for Medicare & Medicaid Services (CMS) mandates several initiatives that prevent improper payments of Medicare Part B and Medicaid claims. The overall goal of the initiatives is to reduce payment errors by identifying and addressing incorrect provider billing. While these edits are not mandatory for non-Medicare/Medicaid medical plans, it is important that the plan manager understand the benefit of these initiatives and their potential value when applied to medical benefit plans.

CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B and Medicaid claims. The coding policies are based on the following:

- Coding conventions defined by the American Medical Association (AMA)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- National and local Medicare policies and edits
- Coding guidelines developed by national societies
- Standard medical and surgical practice

NCCI edits are provided, free of charge, by CMS and are updated on a quarterly basis. The AMA supports the standardization of these code-edit systems and advocates the coordination of effort among all medical claim payers.

Correct Coding Review Scope

CMS has five separate Claims Review programs to help control Medicare and Medicaid costs. The two CMS initiatives that can offer the greatest return benefit to self-funded plans are the:

- Procedure to Procedure Edits, and
- Medically Unlikely Edits (MUEs).

Correct Coding Review Methodology

CTI has developed a way to identify potential overpayments for the medical plans we review as if the CMS guidelines had been applied. These reports also can be used to help plan managers evaluate the strength of their administrator's pre-payment claim review methodologies.

Correct Coding Review Findings

Procedure to Procedure Edits

The **Procedure to Procedure Edits** compare procedure codes from multiple claim lines on the same day. These CMS edits dictate when procedures from multiple lines of a claim cannot be billed together. There are numerous edit algorithms required, as well as many exceptions when code modifiers are used; all good reasons to verify that these CMS edits are being properly implemented and maintained by your administrator. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings potential as if the **Procedure to Procedure Edits** had been in place. The **Procedure to Procedure Edits** are split by CMS into two parts:

- Outpatient hospital services, and
- Non-facility claims (CPT codes 00100-99999)

Following are CTI's NCCI ***Procedure to Procedure Edit*** Reports:

Procedure to Procedure Edits								
Greater than $3,000 Paid								
Based on Paid Dates 01/01/2015 through 02/29/2016								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Modifier**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Modifier**	**Code**	**Modifier**	**Allowed**			**Count**	**Paid**
					none			
						GRAND TOTAL	**0**	**$0**

Non-Facility (non-facility claims with CPT codes: 00100 - 99999)								
Primary		**Secondary**		**Modifier**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Modifier**	**Code**	**Modifier**	**Allowed**			**Count**	**Paid**
45385		45380	51	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	131	$28,563
97140	GP	97530	GP	YES	Manual therapy 1/> regions	THERAPEUTIC ACTIVITIES	375	$12,655
29827	SG	29822	SG	YES	ARTHROSCOP ROTATOR CUFF REP	SHOULDER ARTHROSCOPY/SURGER	7	$12,201
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	55	$10,550
58552		57283	51	NO	LAPARO-VAG HYST INCL T/O	COLPOPEXY INTRAPERITONEAL	14	$7,987
29827	SG	29806	SG	YES	ARTHROSCOP ROTATOR CUFF REP	SHOULDER ARTHROSCOPY/SURGER	1	$7,812
28615	SG	28606	SG	YES	REPAIR FOOT DISLOCATION	TREAT FOOT DISLOCATION	1	$7,482
22630		63047	51	YES	LUMBAR SPINE FUSION	Remove spine lamina 1 lmbr	6	$5,806
28296	SG	28292	SG	YES	CORRECTION OF BUNION	CORRECTION OF BUNION	2	$5,389
37242		75774	26	YES	Vascular embolization or occlusio	ARTERY X-RAY EACH VESSEL	6	$4,973
75774	26	36005	51	YES	ARTERY X-RAY EACH VESSEL	INJECTION EXT VENOGRAPHY	9	$4,542
93505	26	93451	26	YES	BIOPSY OF HEART LINING	RIGHT HEART CATH	12	$4,215
37241		36005	51	YES	Vascular embolization or occlusio	INJECTION EXT VENOGRAPHY	8	$4,038
17110		11100	51	YES	DESTRUCT B9 LESION 1-14	BIOPSY SKIN LESION	56	$4,011
36225	51	36217	51	YES	Place cath subclavian art	PLACE CATHETER IN ARTERY	2	$3,761
29888	SG	64447	SG	NO	KNEE ARTHROSCOPY/SURGERY	N BLOCK INJ FEM SINGLE	5	$3,706
22633		63047	51	YES	LUMBAR SPINE FUSION COMBINE	Remove spine lamina 1 lmbr	4	$3,670
90471		99214		YES	IMMUNIZATION ADMIN	OFFICE/OUTPATIENT VISIT EST	22	$3,576
17110		17000	51	YES	DESTRUCT B9 LESION 1-14	DESTRUCT PREMALG LESION	64	$3,301
29824	SG	29822	SG	YES	SHOULDER ARTHROSCOPY/SURGE	SHOULDER ARTHROSCOPY/SURGER	1	$3,161
45385	33	45380	51	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	12	$3,103
98941		97112		YES	Chiropract manj 3-4 regions	NEUROMUSCULAR REEDUCATION	117	$3,045
						TOTAL over $3,000	**910**	**$147,547**
						GRAND TOTAL	**3,411**	**$885,455**

Medically Unlikely Edits

CMS established units-of service edits referred to as **Medical Unlikely Edits (MUEs).** A **MUE** is defined as an edit that tests claim lines for the same beneficiary, procedure code, date-of-service, and billing provider against a maximum allowable number of service units. **MUEs** are designed to limit fraud and/or coding errors. The **MUE** rule for a given CPT/HCPCS code is the maximum number of service units that a provider should report for a single day of service.

Often, in an automated claims processing system, **MUEs** represent the upper limit that unquestionably requires further documentation to support. For example, electro-cardiogram tracing (CPT code 93005) is limited to three tests per day (three service units) as a hospital outpatient. If the service units exceed three, the individual claim line should be denied.

MUEs are generally based on biological considerations, like number of limbs or organs and are performed on units billed per line-of-service. The same code billed on different lines for the same date-of-service is subject to duplicate adjudication edits where CPT Modifiers like 59, 76, and 77 may impact payment. **MUEs** do not require Medicare contractors to perform manual review or suspend claims; rather, claim lines should be denied and correctly resubmitted by the providers.

Recovery to an employer's plan will vary depending on the cause of the discrepancy, the accuracy of the data submitted by the provider, and the thoroughness of the data collected by the claim administrator. The cause of the **MUE** errors could be incorrect coding, inappropriate services being performed, or fraud. While most of the **Procedure to Procedure Edits** will result in significant recoveries, most of the **MUEs** will result in providers rebilling the procedures, with a slightly lesser payment amount.

The **MUEs** provided by CTI are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

Following are CTI's ***NCCI MUE Edit*** Reports:

NCCI MUE Edits Greater than $2,000 Paid Based on Paid Dates 01/01/2015 through 02/29/2016				
Outpatient Hospital Services (facility claims with codes not designated Inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count**	**Benefit Paid**
		none		
		GRAND TOTAL	**0**	**$0**

Non-Facility (non-facility claims with CPT Codes: 00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count**	**Benefit Paid**
74177	1	CT ABD & PELV W/CONTRAST	16	$12,467
96365	1	THER/PROPH/DIAG IV INF INIT	98	$12,058
90460	6	IM ADMIN 1ST/ONLY COMPONENT	60	$8,939
90853	2	GROUP PSYCHOTHERAPY	71	$5,406
77057	1	MAMMOGRAM SCREENING	30	$5,404
91065	2	BREATH HYDROGEN TEST	5	$4,533
G0202	1	SCREENINGMAMMOGRAPHYDIGITAL	22	$3,990
93306	1	TTE W/DOPPLER COMPLETE	3	$3,719
95861	1	MUSCLE TEST 2 LIMBS	4	$3,338
74178	1	CT ABD & PELV 1/> REGNS	5	$2,878
71275	1	CT ANGIOGRAPHY CHEST	2	$2,773
96413	1	CHEMO IV INFUSION 1 HR	10	$2,633
70496	1	CT ANGIOGRAPHY HEAD	2	$2,449
88377	1	Morphometric analysis, in situ hybr	1	$2,232
70553	1	Mri brain stem w/o & w/dye	3	$2,173
88360	6	TUMOR IMMUNOHISTOCHEM/MANUAL	1	$2,104
C9257	5	BEVACIZUMAB INJECTION	17	$2,099
90837	1	Psytx pt&/family 60 minutes	22	$2,044
		TOTAL OVER $2,000	**372**	**$81,236**
		GRAND TOTAL	**555**	**$110,000**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, and Non-Facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count**	**Benefit Paid**
		none		
		TOTAL OVER $2,000	**0**	**$0**
		GRAND TOTAL	**5**	**$606**

Common Use of NCCI Edits

It is difficult to establish the extent to which administrators and carriers are using NCCI edits as they are only mandated for Medicare and Medicaid payers. However, CTI recommends that these reports be discussed with the client's administrator to determine the extent that CMS edits could be used. Use of these edits would result in a reduction of claim expenses for employers and their employees, as well as furthering efforts toward a standardized code-editing system for all payers.

APPENDIX

SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Claim Universe (as converted)

Stratum	Claim Count	Total Charge Amount	Total Paid Amount
1	345,018	$51,812,808	$21,349,022
2	68,864	$77,329,986	$31,268,286
3	12,522	$160,671,987	$79,248,629
Total	426,404	$289,814,780	$131,865,937

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	345,018	80.91%	60
2	68,864	16.15%	60
3	12,522	2.94%	60
Total	426,404	100.00%	180

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	180	$386,571.87
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	180	$386,571.87
Audit sample if all claims paid correctly	180	$400,926.16
Claims with inadequate documentation	0	$0.00
Total claim payments remaining in audit sample	180	$400,926.16

ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

Cigna's response to the draft report is on the following pages.

Cigna Response

Comprehensive Claim Administration Audit
Specific Findings Report
of

Cigna

for

State of Montana

July 2016

Executive Summary

Cigna would like to thank both the State of Montana and Claim Technologies Incorporated (CTI) for the opportunity to respond to the draft audit findings from the comprehensive claim administration audit conducted in our Denison, TX office the week of May 23, 2016.

The medical claim audit consisted of a Random, Stratified Sample of 180 claims; Targeted sample of 59 claims and an Operational Assessment Questionnaire.

The random claim sample selections were chosen from the time period of claims processed between January 01, 2015 and December 31, 2015. During this time period a total of 426,404 claims were processed representing $131,865,937.00 in claim payments. The random sample of 180 claims represented total dollars paid in the amount of $412,423.28, or 0.31% of the dollars paid.

For the random sample Cigna is in agreement with, and can confirm a total of 11 errors – three (3) overpayments totaling $65.74 and eight (8) underpayments totaling $15,425.42. In addition, there were a total of 17 "out of sample" underpayments totaling $9,085.95. For the Targeted sample, Cigna is in agreement with, and can confirm two (2) overpayments totaling $1,013.75.

Confirmed overpayments have been referred to Cigna's recovery vendor – Accent – and the underpayments have been correctly adjusted.

Cigna's audit methodology for determining accuracy results utilizes a 95% confidence level with a +/- 4% margin of error. Based on this methodology, we are proposing an alternative summary of audit results for the Random sample which does not include the three (3) errors in which we disagree. It is important to note that in calculating the audit results, CTI extrapolates the Financial Accuracy metrics however they do not extrapolate Payment or Processing Accuracy metrics. Cigna has extrapolated all three (3) accuracy metrics Additionally, the following categories, while recognized in CTI's audit report – Adjudication Proficiency and Documentation Accuracy (Financial and Frequency) – are not standard measures currently utilized by Cigna.

Therefore, Cigna recognizes the following results vs. CTI's calculations:

Financial Accuracy – 97.12% (vs CTI's calculation of 96.76%)
Payment Accuracy – 97.50% (vs. CTI's calculation of 92.22%)
Processing Accuracy – 97.50% (vs. CTI's calculation of 92.22%)

It is also important to note that there were two (2) claim errors within the sample (Sample #'s 5 and 56) that were corrected during the audit scope period. Based on

Cigna's experience, errors that are corrected within the scope period are typically not calculated in the audit findings. If we were to exclude these errors, as most audit firms in our experience do, the following results would have been achieved:

Financial Accuracy – 99.42% (vs CTI's calculation of 96.76%)
Payment Accuracy – 97.60% (vs. CTI's calculation of 92.22%)
Processing Accuracy – 97.60% (vs. CTI's calculation of 92.22%)

To address the specific errors identified, we have created a detailed Action Plan that addresses each issue and the steps taken for correction. The Action Plan is included in the following pages of this audit response and we look forward to meeting with the State of Montana to review the results of the audit and Cigna's corrective actions.

***Note:** Cigna has observed that CTI's sample selection methodology differs from what we have experienced in the industry. CTI chose the random, stratified claim sample using billed dollars and Cigna standardly observes claim samples chosen based on paid dollars. In comparison, when the auditing methodology utilizes paid amounts for the stratification rather than billed amounts, we would expect to see a larger percentage of paid dollars and/or more representation of higher dollar paid claims selected for review. For the State of Montana random sample, claims with payments less than $500.00 accounted for 33% of the total sample. In addition, when CTI calculates the results of the audit, the results are then calculated based on paid dollars.

It is important to note that Cigna is not stating that one methodology is more appropriate than another. We are noting that the differences that we have observed with CTI's methodology we do not see currently in the industry; in our experience with other external audit firms or with Cigna's own Performance Guarantee methodologies.

Although there are differences in certain methodologies, Cigna sincerely appreciates the insight and feedback shared by CTI as a result of this audit. We are dedicated to providing exceptional service to all State of Montana customers, and we are committed to taking the necessary actions to correct the errors identified as a result of this audit.

State of Montana
Summary of Client Audit Findings and Remediation
MEDICAL CLAIM AUDIT
Claims processed January 01, 2014 and March 31, 2016

OP = Overpaid
UP = Underpaid
OOS = Out of Sample

Audit Number	Error Category	Financial Impact	Root Cause	Corrective Action	Date Completed
1 25 72 108	Reimbursement	OP $65.43 UP $731.87 OP $0.01 OP $0.30	Allowed Amounts Applied Incorrectly (Manual)	1. Overpayment refund requests forwarded to Accent on 06/14/2016 for #'s 1 - 72 - 108 2. Underpayment correctly adjusted 06/17/2016 for # 25 3. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Refresher review of the claim and the Proclaim Pricing Guidelines SOP with specific attention to allowance of the contract. - In Network vs. Non Par processing - Review of the Manual Claim Overrides SOP and Overrides Codes Guide - Discussion included the necessity to always verify the claim/service level calculations to ensure the correct allowables are reflected, including the OOP. - Review of steps for proper adjudication of the pricing allowables. - A refresher reminder to follow the Claim Processing checklist. - Error review will be conducted with the team by the Supervisor/Quality Coach to assure overall understanding	1. Pending recovery 2. 06/17/2016 3. 05/25/2016; 06/02/2016 & 07/06/2016
5 141 146 152 172 173	Other Insurance / Medicare	UP $14,100.73 UP $39.90 UP $7.37 UP $60.51 UP $0.66 UP $40.86	Cigna Prime; Medicare EOB requested in error / Other Insurance & Medicare allowable applied incorrectly (Manual)	1. Underpayment for Sample # 5 was adjusted prior to audit on 02/06/2015 (15 days after initial denial). 2. Remaining underpayments correctly adjusted on 06/21 & 06/22/2016. 3. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Medicare application reinforcement coaching - Medicare Proclaim Processing SOP	1. 02/06/2015 2. 06/21 & 06/22/2016 3. Between 05/27 & 06/29/2016
OOS 5 OOS 11 OOS 54 OOS 55 OOS 57 OOS 61 OOS 86	Benefit / Coinsurance Application	UP $4.42 UP $47.81 UP $2,911.70 UP $20.00 UP $3,300.91 UP $4.81 UP $376.38	Out of Pocket (OOP) over accumulated (Manual)	1. Underpayments correctly adjusted between 06/17 and 06/22/2016. 2. Coaching provided to individual processors and errors also reviewed with claim teams for further improvement opportunities. Coaching and review included the following: - Manual Claim Overrides SOP and Overrides Codes Guide - Review of necessity to ensure proper verification of claim/service level calculations to ensure the correct allowables are reflected, including OOP	1. 06/17; 06/21 & 06/22/2016 2. 05/25; 05/26; 06/08 & 06/29/2016
OOS 15 OOS 18 OOS 22 OOS 26 OOS 31 OOS 36 OOS 38 OOS 39 OOS 43 OOS 55 OOS 68 OOS 86	Benefit / Copay & Coinsurance Application	UP $100.00 UP $97.42 UP $400.00 UP $300.00 UP $200.00 UP $400.00 UP $55.51 UP $200.00 UP $100.00 UP $67.09 UP $400.00 UP $100.00	Emergency Room (ER) copayment should have been applying to the Out of Pocket (OOP).	1. Underpayments were correctly adjusted on between 06/17 & 06/23/2016. 2. Benefit correction completed on 10/22/2015. 3. Claim impact reporting was requested and is currently in review. Cigna will provide outcome of additional findings once completed.	1. 06/17; 06/22; 06/23 2. 10/22/2015 3. In progress
56	Reimbursement	UP $443.52	Multiple Surgery Reduction should not have applied to this provider.	1. Claim adjusted prior to audit on 05/29/2015, six (6) days after initial claim processing 2. Cigna has in place a process to ensure that claims for this provider that apply the Multiple Surgery Reduction are quickly adjusted as appropriate. This is a system edit to capture all claims in this category. The process has been in place since February 10, 2014.	1. 05/29/2015 2. Ongoing process

ESAS 10	Reimbursement	OP $500.00	Payment of non-covered expense (Orthotics) (Manual)	1. Overpayment refund request forwarded to Accent on 06/14/2016 2. Coaching provided to individual processor on 06/07/2016. Error also reviewed with claim team for further improvement opportunity. Focused of coaching included: Review of Claim Processing Checklist Benefit Verification and review of online Benefit Access tool 3. Cigna is currently reviewing impact reporting received from CTI on 6/29/2016, however we have requested clarification via email and are awaiting CTI's response. Once claim impact reporting is reviewed, Cigna will provide outcome of additional findings upon completion.	1. Pending recovery 2. 06/07/2016 3. In progress
ESAS 11	Reimbursement	OP $513.75	Payment of non-covered expense (Elective Abortion) (Manual)	1. Overpayment identified prior to the audit and refund requests forwarded to Accent on 03/26/2016. 2. Coaching provided to individual processor on 06/07/2016. Error also reviewed with claim team for further improvement opportunity. Focused of coaching included: Review of Claim Processing Checklist Benefit Verification and review of online Benefit Access tool 3. Claim impact reporting was requested and is currently in review. Cigna will provide outcome of additional findings once completed.	1. Pending recovery 2. 06/14/2016 3. In progress
ESAS 5	*Benefits*	*OP $1,722.32*	*CTI's position is that an MRI services for TMJ should have been denied.*	*Cigna continues to respectfully disagree.* *The benefit exclusion for TMJ for the State of Montana states that non-surgical treatment of TMJ is not covered. An MRI is not considered "treatment", but is a diagnostic service. In addition, there was a medically necessary Authorization on file for this claim.* *Based on this information, no further review of claims is warranted.*	
7 *ESAS 6* *ESAS 7*	*Timely Filing*	*OP $643.84* *OP $4,081.72* *OP $921.96*	*CTI's position is that these claims should have been denied for Timely Filing*	*Cigna continues to respectfully disagree.* *Cigna has specific Standard Operating Procedures (SOP), which were provided to CTI during the onsite audit. The SOP states that in the cases when Cigna is secondary to other insurance, we have two (2) years in which to process the claims. This allows our customers the opportunity and time to ensure that the primary insurance is billed and payment made, before submitting to Cigna as the secondary payor.* *In addition, on Sample # ESAS 7, proof of timely filing was provided to CTI. On this claim, the provider provided proof that the claim was mailed to the incorrect address. Per call into Cigna's Customer Service Team, the provider was instructed to submit the claim to the correct address for payment* *Based on this information, no further review of claims is warranted.*	
ESAS 8	*Benefit*	*Additional Observation*	*CTI's has indicated that Cigna does not use the Medicare Physician Fee Schedule Data Base to determine payment policy related to modifiers 26 or TC to lab codes.*	*Cigna continues and will continue to allow payment of automated labs. It has been determined by the courts that a pathologist is entitled to a fee for supervising the lab and its quality control. While other payers (like CMS) have other methods to reimburse the pathologist for this service, Cigna does not.* *In addition, Cigna utilizes coding rules, following the American Medical Association Guidelines.* *Based on this information, no further review of claims is warranted.*	
ESAS 9	*Benefit*	*Additional Observation*	*CTI's recommendation is that the SPD requires an update specifically related to which parts of hearing aids are not covered.*	*Cigna will be happy to work on this potential SPD update directly with the State of Montana.* *The claim identified in the Targeted audit was processed correctly, therefore no further review of claims is warranted.*	
ESAS 12	*Benefit*	*OP $252.89*	*CTI's position is that all services and supplies related to sexual inadequacy or dysfunction are to be excluded.*	*Cigna continues to respectfully disagree.* *The services allowed and paid were for a standard office visit, not for treatment of sexual inadequacy or dysfunction.* *Based on this information, no further review of claims is warranted.*	

ESAS 21	*Subrogation*	*OP $85.68*	*CTI's position is that this claim should have been investigated for potential 3rd party liability, relative to Workers' Compensation*	*Cigna has provided this example to our Subrogation vendor - Xerox - for review.* *The diagnosis code in question - V62.1 - is part of the code range V60-V63 that relates to other psychosocial/economic circumstances and therefore this code has not historically been investigated as it appears to be used when treating mental health issues. Given the sensitivity to mental health care and the wide diagnosis included in the code range, review of these circumstances is not warranted.* *- All other diagnosis codes provided by CTI for potential subrogation investigation are currenlty included in Xerox processes.* *- Cigna has previously provided complete Subrogation Reports to the State of Montana for their review*	
ESAS 24	*High Dollar Claim Review*	*Procedural Deficiency*	*CTI's position is that Cigna's procedures should be reviewed to ensure that all levels of review and approval are being consistently applied.*	*Upon further review, we have confirmed that this claim did go through Cigna's high dollar claim review process.* *Cigna continues to respectfully disagree with the error assigned by CTI. The claim was processed correctly.*	
ESAS 26	*Negotiated Fee Reduction*	*Additional Observation*	*CTI's recommendation is that Cigna should review with the State of Montana why no attempt at obtaining a fee reduction was undertaken.*	*Cigna is currently reviewing the recommendation from CTI, along with the claim, and will advise.*	
General	*Provider Discounts and Fees*	*Additional Observation*	*CTI has observed that there are were in network services where the allowed amount was greater than UCR at the 80%*	*Cigna contracted providers are reimbursed at their contracted rates. UCR would not be applicable in these instances.*	
81	*Benefit / Copay Application*	*UP $8.45*	*CTI's position is that $20.00 copayment should not have applied to supply charges related to an MRI.*	*Cigna continues to respectfully disagree.* *Cigna has an internal SOP (provided to CTI during the onsite audit) that states that charges for items such as contrast material, dyes, etc. are subject to the applicable place of service coinsurance, deductible and/or place of service copayment level of benefits. $20 copayment for office place of service is correct in this instance.*	
134	*Reimbursement*	*OP $370.00*	*CTI's position is that services rendered should have only been reimbursed four (4) times due to "Targeted Case Management per month".*	*Cigna continues to respectfully disagree.* *As provided during the onsite audit, based on the Montana State Statute (# 33-22-515), the statute states the following related to this claim scenario: b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for autism spectrum disorders provided for under this section.* *Therefore, Cigna considers the sample claim processed correctly.*	

Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

State of Montana Dental Plan
Administered by Delta Dental Insurance Company

Audit Period: January 1, 2014 through December 31, 2015

Presented to

State of Montana

May 3, 2016

Presented by

Claim Technologies Incorporated
known in Montana as CTI Claim Audit Technologies Corp.

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INTRODUCTION

This ***Specific Findings Report*** contains information, findings and conclusions from CTI's comprehensive audit of Delta's claim administration of the the State plan(s). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. This ***Specific Findings Report*** is provided to the State, the plan sponsor and Delta, the claim administrator. Delta's response to these findings is included with this report.

The findings in this report are based on data and information the State and Delta provided to CTI and their validity relies upon the accuracy and completeness of that information. CTI conducted the audit according to the standards and procedures generally accepted and in common practice for claim audits in the health insurance industry.

The audit was planned and performed to obtain a reasonable assurance that claims were adjudicated according to the terms of the contract between Delta and the State as well as the approved benefit descriptions (summary plan description(s), plan document(s) or other communications).

CTI is a firm specializing in audit and control of health plan claim administration. Accordingly, the statements made by CTI relate narrowly and specifically to the overall efficacy of the claim administrator's policies, processes and systems relative to the the State's paid claims during the audit period.

Audit Objectives

The specific objectives of CTI's Comprehensive Audit of Delta claims administration were to:

- Quantify dollar amounts associated with claims that the administrator did not pay accurately;
- Determine whether the terms of the agreement for the administrative services between the plan sponsor and claim administrator were followed;
- Determine whether claims were paid according to the provisions of the summary plan description (SPD) and the terms of the SPD were clear and consistent;
- Determine whether members were eligible and covered by the sponsor's dental plans at the time a service paid by Delta was incurred;
- Determine whether any fundamental systems or processes associated with claim administration or eligibility maintenance may need improvement.

Audit Scope

CTI performed a Comprehensive Audit of Delta's claim administration of the the State dental plan(s) for the 12-month period of January 1, 2015 through December 31, 2015. The population of claims and amount paid by the plan(s) during the audit period were:

Total Paid Amount	$7,751,674
Total Number of Claims Paid/Denied/Adjusted	57,301

The audit included the components described below; the objective, scope, methodology and findings of each component are in the following sections of this report.

1. **Operational Review**
   - Operational Review Questionnaire
     - Claim administrator information
     - Claim administrator claim fund account
     - Claim adjudication and eligibility maintenance procedures
     - HIPAA compliance

2. **Plan Documentation Review**
   - Summary plan description(s) and/or plan document(s)
   - Administrative services agreement
   - Review, identification and resolution of ambiguities and inconsistencies

3. **100% Electronic Screening With Targeted Samples (ESAS®)**
   - Systematic analysis of 100% of paid services
   - 10 Targeted samples
   - Problem identification and quantification

4. **Random Sample Audit of 108 Claims**
   - Statistical confidence at 95% +/- 3%
   - Performance level determined for Key Indicators
   - Benchmarking
   - Problem identification and prioritization
   - Recommendations

5. **Data Analytics**
   - Systematic claims analysis for:
     - Provider Discounts

OPERATIONAL REVIEW

OPERATIONAL REVIEW

Objective

The objective of the operational review was to evaluate the systems, staffing, and procedures specifically related to Delta's claim administration of the State's plans and to observe any deficiencies that might materially affect their ability to control risk and accurately pay claims on behalf of the plans.

Scope

The scope of the operational review included the following:

- Claim administrator information
  - Insurance and bonding of the claim administrator
  - Conflicts of interest
  - Internal audit
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Security of data and systems
  - Staffing
- Claim funding
  - Claim funding mechanism
  - Check processing and security
  - COBRA/direct pay premium collections
- Claim adjudication, customer service and eligibility maintenance procedures
  - Exception claims processing
  - Eligibility maintenance and investigation
  - Overpayment recovery
  - Customer service call and inquiry handling
  - Network utilization
  - Appeals processing
- HIPAA compliance

Methodology

CTI gathered operational information from Delta through the use of an operational review questionnaire. The questionnaire is modeled after the audit tool used by CPA firms when conducting an SSAE-16 audit of a service administrator. We have modified that tool to obtain information specific to the administration of the State's plans.

Through review of the responses and the supporting documentation given to us by the administrator, we gained an understanding of the procedures, staffing and systems that related to the administration of the sponsor's plans. This understanding allowed us to be more effective while conducting this audit. To the extent that we noted any uniqueness regarding the systems,

staffing, and procedures that indicated a best-in-practice or improvement potential, we describe them in this section.

In addition to the operational review questionnaire, CTI utilized its proprietary ESAS® software to identify candidate cases to test certain operational processes. We selected a targeted sample of 10 candidate cases and distributed a substantive testing questionnaire to collect information on each. Responses were used to validate that procedures were being followed to control risk and accurately pay claims on behalf of the plan(s).

A complete list of the ESAS screening categories and subcategories used to identify candidate cases for operational review testing is shown in the following chart.

ESAS® Screening Categories and Subsets for Operational Review
Duplicate Payments to Providers and/or Employees
Duplicates within same claim
Coordination of Benefits
Paid primary should be secondary to other group insurance
Active employee, over 65; plan should be primary to Medicare
Retired employee, plan should be secondary to Medicare
Dependent Child Eligibility
Payments for ineligible grandchildren
Payments for over age dependents

Findings

Below are our findings relative to the operational review including:

- Operational review questionnaire
- ESAS and targeted samples of administrative procedures

Claim Administrator Information

CTI reviewed basic information about Delta including background information, financial reports, types and levels of insurance protection, dedicated staffing, systems and software, disclosure of fees and commissions, performance standards and internal audit practices. From our review we offer the following observations:

- Delta provided insurance certificates documenting its levels of coverage for errors and omissions (E and O), its fidelity bond, and cyber liability. The coverage levels comply with the limits specified in the State's Third Party Administration Agreement. The E and O and cyber liability coverage certificate is issued to Dentegra Group, Inc. and the fidelity bond is issued to Delta Dental of California and its subsidiaries. Delta should provide written confirmation that it is covered as an insured under these policies.

- Delta provided a copy of its self-reported results against performance guarantees specific in its Third Party Administration Agreement. CTI's independent audit confirmed that Delta's performance exceeded contractual guarantees for claims accuracy.
- Delta assigned a designated account executive and account manager to serve the State of Montana. Since Delta did not indicate that customer service analysts (CSAs) and other administrative staff are dedicated to the State, CTI assumes that these staff also provided service to other Delta clients. In view of some of the errors in claim processing noted during the random sample audit, CTI recommends that Delta consider dedicating claim processing staff to the State, or alternatively, provider refresher training to ensure the State's benefits are processed in conformance with the State's plans.
- Delta complied with the standards of the American Institute of Certified Public Accounts (AICPA) through issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 16, reporting on controls at a service organization, which replaces the prior SAS 70 Report. Under SSAE 16, the administrator was required to provide its own description of its system, which the service auditor validates. The administrator's external auditor, Armanino LLP, did not note any exceptions for controls related to claims processing.
- Delta confirmed that no services have been outsourced to any subcontractors during the audit period.

Claim Funding

CTI reviewed information specific to controls and procedures related to claim checks including claim funding, fund reconciliation, handling of refunds and returned checks, large check approval, security, disposition of stale checks and appropriate audit trail reports, and COBRA and retiree/direct pay premium collection. From our review we offer the following observations:

- Delta has very effective procedures for recovery of overpayments. If an overpayment is made to a participating dentist, the overpayment is recovered by withholding payment from future checks. Overpayments made to members are recovered by "flagging" the member and applying the overpayment before additional payments are made. If Delta is responsible for an overpayment and funds cannot be recovered, it will credit the State's account at its own expense for the amount of the overpayment.
- Delta's claim system includes internal flags so that claims which require professional review are referred to dental consultants prior to being paid. This is an effective internal control to ensure the dental necessity and reasonableness of claim payment. In addition, Delta's consulting dentists are the only claim processors with authority to override fee determinations.

Claim Adjudication, Customer Service and Eligibility Maintenance Procedures

CTI reviewed information specific to the controls and procedures used by Delta related to enrollment, eligibility maintenance and processing of claims. From our review we offer the following observations:

- Delta had adequately documented training, workflow, procedures and systems to provide consistently high levels of accuracy in the processing of claims and enrollment.

- Delta has no procedures for investigating eligibility of dependents and relies on the State for providing accurate eligibility status.
- Delta collects information about other dental coverage during initial enrollment and accepts updates to other coverage information submitted with eligibility at any time. Following entry of initial coordination of benefits (COB) information, subsequent validation is performed on a claim-by-claim basis. CTI noted during the random sample audit that Delta relies on information from providers as the basis for COB information, rather than independently investigating the potential for other coverage.
- Delta updates its fees at least annually based on many factors including network size, overall discount and competitive market conditions. In Montana, Delta PPO fees are 24% less than submitted charges. The Delta Dental Premier fees were 15% less than average submitted charges. These discount levels were confirmed during CTI's independent analysis.
- As is typical for dental claim administrators, Delta does not actively pursue subrogation investigation and recovery.
- Delta provided a copy of its claim complaint/appeal log for the audit period. Only 20 appeals were filed; 60% of these upheld Delta's initial determination.

HIPAA Compliance

CTI reviewed information specific to the systems and processes Delta had in place to maintain compliance with HIPAA regulations. The objective of this questionnaire segment was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. From our review we offer the following observation(s):

- Although Delta did not provide copies of its policies and procedures confirming HIPAA compliance, because it considers them confidential and proprietary, it did provide a general statement about its implementation of comprehensive policies and procedures that address required protections for privacy and security.
- Training on HIPAA security and privacy requirements is required for all new employees and other employees receive refresher training.

PLAN DOCUMENTATION REVIEW

PLAN DOCUMENTATION REVIEW

Objectives

The objective of the plan documentation review was to evaluate the documents governing the administration of the State 's dental plan(s) and identify any inconsistencies or ambiguities that might negatively impact accurate claim administration. Through this evaluation of documents we gained an understanding of the benefit plan and Delta's administrative service responsibilities that related to claim administration of the State's dental plan(s). This understanding allowed us to be more effective throughout the audit. To the extent we noted issues within the plan documentation we describe them in this section.

Scope

Our auditors evaluated the following:

- Plan documents/summary plan descriptions and all amendments:
  - Summary Plan Description Revised April 8, 2013
  - 2013 Retiree Booklet
  - Annual Change Books for Actives and Retirees
  - Diagnostic and Preventive Waiver Amendment
  - Alternate Benefit Amendment for fillings for Basic Plan
- Administrative services agreement

Methodology

CTI obtained a copy of the plan documentation from the State.

Our auditors reviewed the applicable plan document and summary plan description (SPD) very closely as these documents describe the benefit plan provisions the claim administrator should be using to adjudicate all dental claims for Delta. To assist them in understanding those provisions they used a tool we developed for this purpose called a benefit matrix. CTI's benefit matrix is a composite listing of the benefit provisions, exclusions and limitations we expect to see in a plan document or SPD. When completed, the matrix allows us to identify inconsistencies and missing provisions.

CTI obtained clarification from the State regarding any inconsistencies or missing provisions in the plan document(s)/SPD(s). The benefit matrix was then used by our auditors as a cross reference tool as they audited claims.

Findings

CTI found no ambiguities in the coverage documents. We note, however, that Delta has disagreed with some of the errors cited by CTI because of provisions in agreements or guidelines in place with participating dentists. If the State agrees with Delta's guidelines, these coverage limitations should be included in coverage documents.

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES (ESAS®)

100% ELECTRONIC SCREENING WITH TARGETED SAMPLES (ESAS®)

Objective

The objective of ESAS with targeted sampling was to identify and quantify potential claim administration payment errors. If over- or under-payments were identified and subsequently verified, the State and Delta can work together to determine appropriate resolution to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by Delta during the audit period plus the prior 12 months. During that period the administrator processed 89,913 claims (including adjustments) for 26,794 of the State's claimants representing 288,852 separate service line items and resulting in $15,763,598 in payment by the plan(s). CTI screened claims in up to 45 different categories and applied more than 400 unique algorithms when electronically screening this claim data. The accuracy and completeness of the claim data we were provided by the administrator directly impacts which screening categories we were able to run and the integrity of our findings. Following is a high level summary of the ESAS screening categories and subcategories for which we screened:

Summary of ESAS® Screening Categories to Identify Potential Amounts at Risk
Duplicate Payments to Providers and/or Employees
Duplicates from two claims
Duplicates from three or more claims
Plan Limitations
Specific to plan provisions such as: • Dollar limitations • Number of visit limitations
Payments after timely filing limit
Plan Exclusions
Specific to plan provisions such as: • Dental, Periodontics • Dental, Extractions Other Impactions • Dental, Extractions Bony Impactions • Dental, Other Anesthesia • Dental, Other Surgical Procedures • Dental, Miscellaneous Services

Methodology

The specific procedures followed to complete our ESAS with targeted sampling process of claim data for the State were as follows:

- *Electronic Screening Parameters Set* – We relied upon the plan provisions of the State's dental plan SPD(s) to set the parameters in our electronic screening system.
- *Data Conversion* – We converted and validated the claim data provided by Delta. The converted data was reconciled against control totals and checked for reasonableness.
- *Electronic Screening* – We systematically screened 100% of the service lines processed by Delta. Claims that were not processed in accordance with the parameters of the plan(s) were flagged. CTI refers to these potential errors as red flagged.
- *Auditor Analysis* – If red flagged claims within an ESAS screening category represented material amounts, our auditors analyzed the category findings to confirm that the findings were valid. When using electronic screening to identify payment errors in claims, false positives occurred because certain claim data was misleading or inadequate. CTI auditors make every effort through the analysis to identify and remove false positives.
- *Targeted Samples* – From the categories where material amounts were identified, CTI auditors selected the best examples of potential over- or under-payments to test. These cases were not randomly selected therefore no extrapolation of the test results could be made. For this audit, a total of 10 red flagged cases were selected. For each case a substantive testing questionnaire was prepared and sent to Delta for completion. Targeted samples served to verify if the claim data provided by the administrator supported our electronic screening; and, if our understanding of the plan provision governing how that service should be adjudicated matches that of Delta.
- *Audit of Administrator Response and Documentation* – A CTI auditor reviewed the substantive testing questionnaire responses. Based on the responses from Delta and further analysis of the ESAS findings in light of those responses, we removed any false positives that could be systematically identified from the potential amounts at risk.

Findings

While we are confident in the accuracy of our electronic screening results, it is important to note that the dollar amounts associated with the results represent *potential* payment errors and process improvement opportunities. Additional testing of these claims would be required to substantiate the findings and to provide the basis for remedial action planning or reimbursement.

Additionally, CTI was and is not authorized to tell Delta to recover overpaid amounts. The process and impact of recovering overpayments must be discussed by the State and the administrator. If recovery is not pursued, these findings still represent the opportunity for future savings if systems and procedures are improved to eliminate similar payment errors going forward.

The following ***ESAS Summary Report*** shows, by category, the number of line items or claims and the total potential amount at risk that remains at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the ***ESAS Summary Report*** is a detailed explanation of our substantive testing results, findings and recommendations for any screening category where it is our opinion that, process improvement(s) or recovery/savings opportunities exist.

Please Note: If CTI is making an improvement recommendation, it will be denoted by a **Yes** in the right hand column of the ***ESAS Summary Report***.

ESAS Summary Report

Categories for Potential Amount At Risk

Client: MTDEN16
Screening Period: 01/01/2014 - 12/31/2015

Analysis Final Results

Claims Red Flagged	2,050
Claimants Red Flagged	1,715
Paid Amount Red Flagged	$666,935
Potential Amount at Risk:	$566,758

Category	Lines	Clmts	Description	Charge Amount	Paid Amount	Potential Amount At Risk	Improvement Recommended
Duplicate Payments to Providers and/or Employees							
DP2C	676	55	Duplicate Payments to Providers and/or Employees	$11,863	$23,572 *	$11,709	
Plan Limitations							
PL01	238	173	Oral Exam 2 per Benefit Year 2014	$12,801	$8,891	$8,891	
PL02	880	781	Oral Exam 2 per Benefit Year 2015	$45,579	$31,898	$31,898	
PL04	1	1	Bitewings 2 per Benefit Year 2015	$77	$47	$47	
PL05	70	63	Full Mouth X-ray Once Every 5 Years	$7,277	$5,467	$5,467	
PL06	2	2	Cleanings 2 per Benefit Year 2014	$143	$108	$108	
PL07	13	9	Cleanings 2 per Benefit Year 2015	$1,086	$824	$824	
PL08	1	1	Fluoride 2 per Benefit Year 2014 to age 19	$31	$29	$29	
PL09	1	1	Fluoride 2 per Benefit Year 2015 to age 19	$33	$22	$22	
PL11	218	59	Implants over $1,500	$308,407	$129,457	$40,956	
TFLM	14	4	Timely Filing (Last service date to received date)	$1,170	$566	$566	
Plan Exclusions							
DX17	1183	328	Dental, Extractions Bony Impactions	$449,230	$257,449	$257,449	
DX22	1515	644	Dental, Other Anesthesia	$324,677	$208,793	$208,793	

* The amount detailed is based on Benefit Total, which equals Coinsurance + Copayment + Deductible + Paid

Duplicate Payments

***Objective*:** Identify provider services paid more than once. We also identify procedural deficiencies of the administrative process and conservatively quantify the additional cost to a plan caused by duplicate payments.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain service lines may have been paid more than once, resulting in a benefit total (the accumulation of payment, deductible and coinsurance applied to the out-of-pocket accumulation) greater than the charged amount for that service. Additional analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) number(s) 1 and 3 were sent to Delta.

Results are shown in the following report entitled ***Substantive Testing Detail Report – Duplicate Payments.*** The results indicate there were no errors found.

Recommendation(s)

In the category of Duplicate Payments, CTI recommends that Delta continue its diligent processing of claims to ensure compliance.

Substantive Testing Detail Report – Duplicate Payments

Questionnaire ID Numbers: 1 and 3

QID No:	Flag Type	Flag Description	Overpaid Amt	Delta Response
1	DUPS	Duplicate Payment	$0.00*	Not a duplicate. Services only incurred once.
3	DUPS	Duplicate Payment	$0.00*	Not a duplicate. Claim is for twins.

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

Plan Limitations

***Objective*:** Identify services that exceed plan limitations on quantity, frequency or benefit amount. We also identify procedural deficiencies in the administrative process and conservatively quantify the additional cost to the plan(s) caused by payments in excess of the plan(s) limitations.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed that no service lines were overpaid as a result of exceeding the plan's limitations for coverage.

Additional analysis of the service lines flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) number(s) 4-10 were sent to Delta. The results indicate there were no errors found.

Recommendation(s)

In the category of Plan Limitations, CTI recommends that Delta continue its diligent processing of claims to ensure compliance.

Substantive Testing Detail Report – Plan Limitations

Questionnaire ID Numbers: 4 thru 10

QID No:	Flag Type	Flag Description	Overpaid Amt	Delta Response
4	PL01	Oral Exam 2 per Benefit Year 2014	$0.00*	Exams for procedure code D0120 and D0140 are benefitted separately.
5	PL01	Oral Exam 2 per Benefit Year 2014	$0.00*	Exams for procedure code D0120 and D0140 are benefitted separately.
6	PL05	Full Mouth X-ray Once Every 5 Years	$0.00*	Exams for procedure code D0210 and D0330 are benefitted separately.
7	PL05	Full Mouth X-ray Once Every 5 Years	$0.00*	Exams for procedure code D0210 and D0330 are benefitted separately.
8	PL11	Implants over $1,500	$0.00*	The $1,500 lifetime maximum for implants was not exceeded.
9	PL11	Implants over $1,500	$0.00*	The $1,500 lifetime maximum for implants was not exceeded.
10	PL11	Implants over $1,500	$0.00*	The $1,500 lifetime maximum for implants was not exceeded.

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

Plan Exclusions

***Objective*:** Identify services that should have been denied due to specific exclusions defined in the summary plan description (SPD) or plan document(s). We also identify procedural deficiencies in the administrative process and quantify conservatively the additional cost to a plan(s) caused by the payment of excluded expenses.

Initial Screening and Analysis

Electronic screening of all service lines processed revealed certain services may have been overpaid as a result of paying for services that should have been denied due to exclusions defined in the SPD or plan document(s).

Additional analysis of the services flagged confirmed the potential for process improvement and overpayment of claims to be sufficiently material to warrant further testing.

Substantive Testing

Substantive testing questionnaire (QID) number 11 was sent to Delta. The results indicate there were no errors found.

Recommendation(s)

In the category of Plan Exclusions, CTI recommends that Delta continue its diligent processing of claims to ensure compliance.

Substantive Testing Detail Report – Plan Exclusions

Questionnaire ID Numbers: 11

QID No:	Flag Type	Flag Description	Overpaid Amt	Delta Response
11	DX17	Dental, Extractions Bony Impactions	$0.00*	Services only incurred once.

*Potential overpayments that were tested and determined to not be overpaid have been removed from total potential overpaid, however other cases identified by ESAS® cannot be removed without further investigation.

RANDOM SAMPLE AUDIT

RANDOM SAMPLE AUDIT

Objectives

The objectives of our random sample audit were to determine that claims were paid in accordance with plan specifications and the administrative agreement, to measure and benchmark administrative process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

The scope of our random sample audit included the audit of a stratified random sample of 108 paid or denied claims. The claims were audited at CTI's offices in Des Moines, IA. The statistical confidence level of the audit sample was 95%, with a 3% margin of error. A copy of the ***Sample Construction and Weighting Methodology Report*** for this audit sample is provided in Appendix A.

The administrator's performance was measured using Key Performance Indicators as follows:

- Financial Accuracy Rate
- Accurate Payment Frequency
- Accurate Processing Frequency
- Adjudication Proficiency
- Documentation Accuracy – Financial
- Documentation Accuracy – Frequency

We also measured claim turnaround time, which is a commonly relied upon measurement of claim administration performance.

Our auditors may have also made additional observations regarding processes or payments that went beyond the scope of our random sample audit. If so, those observations are reflected in this section of the report.

Methodology

Each sample claim selected was reviewed to ensure it conformed to the plan specifications, agreements, and negotiated discounts. Findings were recorded in CTI's proprietary audit system.

When applicable, errors were cited if a claim selected in the random sample was paid or processed incorrectly based on member eligibility or plan provisions as defined in the SPD(s) or amendments. Payment errors were observed based on the way the selected claim was paid and the information Delta had at the time the transaction was processed. If the sampled claim was subsequently corrected, the error was still cited so the plan sponsor can discuss how to reduce errors and re-work in the future with the State.

CTI communicated with the administrator about any errors or observations in writing using system generated observation response forms.

A preliminary ***Random Sample Audit Report*** was sent to Delta for review and response in writing. Delta response was considered when producing the final ***Specific Findings Report*** and is provided in Appendix B. Ultimately, the payment and procedural errors remaining were accumulated and used to determine results for each Key Performance Indicator. Definitions of the Key Performance Indicators are provided in this section along with their respective results.

Moving forward, the process and impact of improving processes and adjusting payment errors identified through this random sample audit should be discussed between the State and Delta.

Findings

Performance, as measured by the random sample audit for each Key Performance Indicator, is presented in the pages immediately following.

Financial Accuracy Rate

***Operational Definition*:** The total correct claim payments that were made compared to the total dollars of correct claim payments that should have been made for the audit sample. The formula for this measure is: *Total correct payments (claims paid in the sample minus overpayments plus underpayments) minus the absolute variance (overpayments plus underpayments) divided by total correct payments.*

Claims sampled and reviewed by CTI revealed $241 in underpayments and $113 in overpayments, for a combined variance of $354.

The correct payment total for the adequately documented claims in the audit sample should have been $26,834. Note that CTI only uses adequately documented claims for this calculation.

- Financial accuracy rate for the claims sampled for this audit period was 98.68%.
- On a weighted, adjusted basis for the audit universe financial accuracy rate was 99.18**%.**

Each error found in the random sample audit is listed in the following error detail report titled ***Financial Accuracy Rate and Accurate Payment Frequency***.

Error Detail Report: Financial Accuracy Rate and Accurate Payment Frequency

Audit Numbers: 1001 - 1108

Primary Cause	Indicator Description	CTI AuditNo.	Claim No.	Entered Amount	Correct Amount	Under Paid	Over Paid
DEE	Denied eligible expense						
	1087	20152513401448		$353.60	$594.60	($241.00)	$0.00
	Subtotal:	1		$353.60	$594.60	($241.00)	$0.00
FL	Frequency limits not applied						
	1009	20151416037039		$200.00	$151.00	$0.00	$49.00
	1055	20150646031286		$168.00	$104.00	$0.00	$64.00
	Subtotal:	2		$368.00	$255.00	$0.00	$113.00
Total Number of Claims:	3					($241.00)	$113.00

Accurate Payment Frequency

***Operational Definition*:** The number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 3 incorrectly paid claims and 101 correctly paid claims.

The incorrectly paid claims were comprised of 1 underpaid claim(s) and 2 overpaid claim(s). Note that CTI only uses adequately documented claims for this calculation.

Accurate payment frequency for the claims sampled was 97.12%.

Each error found in the random sample audit is listed in the error detail report shown in the preceding report titled ***Financial Accuracy Rate and Accurate Payment Frequency***.

Accurate Processing Frequency

***Operational Definition*:** The number of claims processed without errors compared to the total number of claims processed in the audit sample.

When a claim had errors that applied in more than one category, it was counted only once as a single incorrect claim for this measure.

The audit sample revealed 101 claim(s) processed without any type of error, while 7 claim(s) had one or more errors.

Accurate processing frequency for the sample and all claims processed during the audit period was 93.52%.

There is no error detail report for this performance indicator since the specific errors are referenced in respect to other measures in this report.

Adjudication Proficiency

***Operational Definition*:** The number of correct adjudication decisions made compared to the total number of adjudication decisions required for the claims within the audit sample.

There were 832 separate decisions reviewed during the audit period and an average of 8 decisions for each claim was reviewed to determine adjudication proficiency. 7 adjudication errors were observed in the audit sample.

Adjudication proficiency for the claims sampled and all claims in the universe was 99.16%.

The adjudication errors found in the random sample audit are in the following ***Adjudication Proficiency*** error detail report. Adjudication errors can result in payment errors and/or may have been the result of inadequate documentation. To the extent that this has occurred, the same CTI audit numbers may appear on more than one report.

Error Detail Report: Adjudication Proficiency

Audit Numbers: 1001 - 1108

Error Type	Question Description	Indicator	Indicator Description	Examiner Flag	CTI Audit	LineNo.	Provider ID
ADJUD	COB Investigation	OIDI	Other insurance documentation inadequate		1012		
ADJUD	COB Investigation	OIDI	Other insurance documentation inadequate		1033		
ADJUD	COB Investigation	OIDI	Other insurance documentation inadequate		1034		
ADJUD	COB Investigation	OINI	Other insurance not investigated		1056		
	4 COB Investigation						
ADJUD	Policy Provisions	DEE	Denied eligible expense		1087	005	
ADJUD	Policy Provisions	FL	Frequency limits not applied		1009	001	
ADJUD	Policy Provisions	FL	Frequency limits not applied		1055	001	
	3 Policy Provisions						

Examiner Error:	7
System Error:	0
Total Count:	7

Documentation Accuracy – Financial

***Operational Definition*:** The dollar amounts processed with documentation adequate to substantiate payment or denial compared to the dollar amounts processed in the audit sample.

The audit sample revealed 4 inadequately documented payments and represented a total paid claim amount of $1,864. An inadequately documented payment does not produce enough evidence to establish that the payment amount was correct. With this in mind, CTI removed inadequately documented payment amounts from the denominator (total of correctly paid claim amounts) used to calculate other financial measures (reference financial accuracy rate and COB savings in this report) in the audit, as that denominator assumed the payment amounts was correct.

Documentation accuracy – financial for the claims sampled for this audit period was 93.48%.

On a weighted, adjusted basis for the audit universe documentation accuracy – financial was 95.24%.

Each error found in the random sample audit is listed in the following report titled, ***Documentation Accuracy – Financial and Frequency***.

Error Detail Report: Document Accuracy – Financial and Frequency

Audit Numbers: 1001 - 1108

CTI Audit No: Claim No.

Error Type	Line No.	Question Description	Error Indicator	Error Indicator and Description	Info Indicator	Info Indicator and Description	Charge Amt	Paid Amt
1012	20150163400820						$875.00	$200.00
ADJUD		COB Investigation	OIDI	Other insurance documentation inadequate	CDP	Claimant is child with divorced parents		
1033	20151873405665						$188.00	$117.00
ADJUD		COB Investigation	OIDI	Other insurance documentation inadequate	OI	Other insurance indicated in file		
1034	20153386039134						$1,931.00	$1,131.20
ADJUD		COB Investigation	OIDI	Other insurance documentation inadequate	OI	Other insurance indicated in file		
1056	20152013417120						$2,086.00	$416.00
ADJUD		COB Investigation	OINI	Other insurance not investigated	OI	Other insurance indicated in file		
							$5,080.00	$1,864.20

Total Number of Claims: 4

Documentation Accuracy – Frequency

***Operational Definition*:** The number of claims processed with documentation adequate to substantiate payment or denial compared to the total number of claims processed in the audit sample.

The audit sample revealed 4 inadequately documented payments and represented a total paid claim amount of $1,864. An inadequately documented payment does not produce enough evidence to establish that the payment amount was correct. With this in mind, CTI removed inadequately documented payment amounts from the denominator (total of correctly paid claim amounts) used to calculate other financial measures (reference financial accuracy rate and COB savings in this report) in the audit, as that denominator assumed the payment amounts was correct.

Documentation accuracy – frequency for the audit sample was 96.30%.

Each error found in the random sample audit is listed in the error detail report titled ***Documentation Accuracy – Financial and Frequency*** which are in the preceding section.

Claim Turnaround

***Operational Definition*:** The number of calendar days required to process a claim – from the date the claim is received by the administrator to the date a payment, denial or additional information request is processed – expressed as both the Mean and Median for the audit sample.

Median claim turnaround time for the sample was 1 day(s) from *the date received by the claim administrator* to the *date the claim was processed*. One of the claims in the sample took 45 days or longer to process. Same day turnaround on claims is the fastest turnaround time that can be achieved – but it is not necessarily the best turnaround time. The administrator should balance claim turnaround by handling all types of claims as efficiently as possible.

A detailed claim turnaround analysis is in the following report titled ***Claim Turnaround Analysis.***

NOTE: Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for the administrator to focus on when analyzing claim turnaround because it prevents one or a few claims with extended turnaround time(s) from distorting the true performance picture. The mean claim turnaround from *date received* to *date processed* was 4 day(s).

Claims Turnaround Analysis – Paid and Pended

Audit Numbers: 1001 - 1108

Audit	Claim Number	Last Service	To	Date Signed	To	Date Complete Clm Rcvd by	To	Process Date	To	Date EOB/Ck Mailed	Total Days
		*Pended Claims Averages:	0		0		0		0		0
		Non-Pended Claims Averages:	3		10		4		7		24
		Combined Averages (Pended && Non-Pended):	3		10		4		7		24

Number of Days Between Received and Processed Dates:

1 Day.	58	26 Days.	0
2 Days.	14	27 Days.	0
3 Days.	13	28 Days.	0
4 Days.	3	29 Days.	0
5 Days.	7	30 Days.	0
6 Days.	1	31 Days.	0
7 Days.	1	32 Days.	0
8 Days.	1	33 Days.	0
9 Days.	1	34 Days.	0
10 Days.	2	35 Days.	0
11 Days.	1	36 Days.	0
12 Days.	3	37 Days.	0
13 Days.	2	38 Days.	0
14 Days.	0	39 Days.	0
15 Days.	0	40 Days.	0
16 Days.	0	41 Days.	0
17 Days.	0	42 Days.	0
18 Days.	0	43 Days.	0
19 Days.	0	44 Days.	0
20 Days.	0	45 Days	0
21 Days.	0	> 45 Days	1
22 Days.	0	Undetermined:	0
23 Days.	0	Total Number of Claims:	108
24 Days.	0		
25 Days.	0		

	Days:
Median:	1

Additional Findings and Observations

During the course of the random sample audit, procedures or situations were observed that may not have caused an error on the sampled claim – but may have an impact on future claims or the overall quality of service. These additional observations are summarized in the following table.

Additional Observations	CTI Audit Number
CTI notes that Delta has limited the benefit for porcelain crowns on posterior teeth to that of metal crown on this bridge claim. Delta had previously stated on CTI 1037 that the State of Montana plan design does not alternate benefit porcelain/ceramic crowns or bridges for the Premium Plan. After further research, it was discovered that the State of Montana is setup to not alternate-benefit for crowns (major restorative); however, dentures/bridges (prosthodontics) are alternate benefitted. The State of Montana and Delta should discuss this issue and determine if the alternate benefit policy should apply to denture/bridge services as well.	1086
Delta recouped benefits for services paid and incurred in 2015 in March of 2016. This reduced the benefits paid to the member for B&C type services in 2015 to $772.00. Delta will adjust the previously denied 2015 services until the patient has reached the 2015 dental plan maximum.	1090
The State of Montana should be made aware that Delta Dental requires x-rays be submitted, that are not reviewed by Delta Dental, in order to pay for implant service.	1102
The State of Montana should be made aware that Delta Dental paid this patient's replacement crown within the dental plan's five year limiting period.	1102

Additional Audit Results	
COB savings (unweighted)	0.24%*
Record retrieval capability – percent of claims selected for audit sample for which complete records were produced	100%**

*COB savings was calculated based on the audit sample using the claim dollars saved by the plan(s) through coordination with other group plans and Medicare as a percentage of the correct total claim dollars paid. The random sample audit further showed that COB savings, if all claims had been coordinated correctly, would have been 0.24% of paid claims.

**108 claims initially were requested for the audit sample. The administrator provided documentation for all requested claims.

DATA ANALYTICS

DATA ANALYTICS

This component of the audit used the electronic claim data to provide additional meaningful information. The standard informational categories we analyzed the data for include:

- Network provider utilization and savings

Other data analytics can be performed at the plan sponsor's request if the data provided by the claim administrator supports it.

Provider Utilization and Discount Savings

Objective

The objective of CTI's provider discount review was to provide the plan sponsor with an evaluation of their provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, CTI believes calculating discounts in the same manner for all of its audit clients allows for meaningful comparisons to be made.

Scope

CTI's ***Provider Utilization and Discount Savings Report*** compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three sub-sets:

- In-network;
- Out-of-network; and
- Secondary networks.

Each of the above mentioned sub-sets was further delineated into four sub-groups:

- Ancillary services;
- Non-facility services;
- Facility inpatient; and
- Facility outpatient

Methodology

The following ***Provider Utilization and Discount Savings Report*** relied on the data provided by the administrator and only used the data fields provided with no assumptions made when necessary data fields were not provided by the administrator.

Findings

Provider Discount Review
Paid Dates 01/01/2015 through 12/31/2015

Total of All Claims

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$0	$0	0.0%	$0
Non-Facility	$14,603,291	$4,358,237	29.8%	$7,745,964
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total	**$14,603,291**	**$4,358,237**	**29.8%**	**$7,745,964**

In-Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$0	$0	0.0%	$0
Non-Facility	$9,680,143	$2,509,985	25.9%	$5,468,525
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total In-Network	**$9,680,143**	**$2,509,985**	**25.9%**	**$5,468,525**
% of Allowed Charge -	66.3%	% Claim Frequency -	70.5%	

Out of Network

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$0	$0	0.0%	$0
Non-Facility	$4,923,148	$1,848,252	37.5%	$2,277,439
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Out of Network	**$4,923,148**	**$1,848,252**	**37.5%**	**$2,277,439**
% of Allowed Charge -	33.7%	% Claim Frequency -	29.5%	

Secondary

Claim Type	Allowed Charge	Provider Discount		Paid
Ancillary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Allowed Charge -	0.0%	% Claim Frequency -	0.0%	

Allowed Charge *- Provider Discount + Deductible + Copayment + Coinsurance + Paid Amount*

Facility Inpatient *- Room and Board Revenue Codes (100-219)*

Facility Outpatient *- Revenue Codes not Flagged as Inpatient*

Non-Facility *- CPT Codes: 00100 - 99999*

Ancillary *- All other claims not flagged in Inpatient, Outpatient and Non-Facility*

APPENDIX

SAMPLE CONSTRUCTION AND WEIGHTING METHODOLOGY

Client: MTDEN16
Audit Period: January 01, 2015 - December 31, 2015

Claim Universe (as converted)

Stratum	Claim Count	Total Charge Amount	Total Paid Amount
1	43,448	$5,975,526	$3,811,353
2	9,721	$4,716,734	$1,933,189
3	4,132	$7,561,573	$2,007,132
Total	57,301	$18,253,834	$7,751,674

Audit Stratification

Stratum	Audit Universe (# Claims)	Proportion (Weight by Count)	Sample
1	43,448	75.82%	36
2	9,721	16.96%	36
3	4,132	7.21%	36
Total	57,301	100.00%	108

Audit Sample Overview

Category	Count	Paid
Claims requested for audit	108	$28,570.39
Claims for which records not received	0	$0.00
Claims outside scope of audit	0	$0.00
Claims as entered included in audit sample	108	$28,570.39
Audit sample if all claims paid correctly	108	$28,698.39
Claims with inadequate documentation	4	$1,864.20
Total claim payments remaining in audit sample	104	$26,834.19

ADMINISTRATOR'S RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

DELTA DENTAL

Delta Dental Insurance Company

April 25, 2016

Mr. Daniel Montgomery
Claim Technologies Incorporated
100 Court Ave., Suite 306
Des Moines, IA 50309

Re: The State of Montana – Audit Report

Dear Dan:

Thank you for the opportunity to review the draft audit report for our mutual client, The State of Montana. As always, CTI has done a thorough and comprehensive review of Delta Dental and we appreciate the opportunity to partner with you to identify areas where we can improve service to The State of Montana and its members.

The State of Montana is a long-time valued and important client of Delta Dental. As such, we want to assure that we are meeting their expectations at all times. We wanted to highlight a few items for clarification and comments based on our review of the audit report:

1. CTI # 1009: Delta Dental disagrees. Claim submitted with procedure D2393 (Amalgam – four or more surfaces) on tooth # 30. Tooth #30 is in history for surface DO. The claim is allowed to pay since it was processed under a different Tax ID (Provider) than the claim in history. The claim properly adjudicated based on our processing policies.
2. CTI # 1055: Delta Dental disagrees. Both restorations, D2391 (Resin-based Composites – one surface), were allowed on tooth # 19 because our system does not do partial surface matches. The claim system will only deny payment when there is an exact surface match. Procedure was done at the same practice location. The claim properly adjudicated based on our processing policies.
3. CTI # 1087: Delta Dental disagrees. D7953 (Bone Replacement Graft) is not a covered benefit of the State of Montana plan. Claim processed correctly.

We look forward to jointly discussing the results of this audit at a future meeting. Once again, thank you for your continued partnership.

Sincerely,

Chris Hinds
Director, Sales

Brittany Chandler
Account Manager

55 West 14th Street
Suite 101
Helena, MT 59601

Telephone: 800-547-1986
Telephone: 406-449-0255
Facsimile: 406-495-0322

Prescription Benefit Management Audit

SPECIFIC FINDINGS REPORT

State of Montana
Administered by MedImpact

Audit Period: January 1, 2014 – December 31, 2015

Presented to

State of Montana
August 16, 2016

Prepared by

TRICAST LLC

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

PREFACE

This ***Specific Findings Report*** contains detailed information, findings, and conclusions that the TRICAST, LLC (TRICAST) audit team has drawn from their Prescription Benefit Management Audit of MedImpact's administration of the State of Montana pharmacy plan(s). The statistics, observations, and findings in this report constitute the basis for the analysis and recommendations presented under separate cover in the ***Executive Summary***. This ***Specific Findings Report*** is provided to the State of Montana, the plan sponsor, and MedImpact, the pharmacy benefit manager.

The findings in this report were based on data and information the State of Montana, as the plan sponsor, and MedImpact, as the pharmacy benefit manager (PBM) provided to TRICAST and their validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between MedImpact and the plan sponsor, as well as the benefit descriptions (summary plan descriptions(s), plan document(s) or other communications) approved by the State of Montana.

TRICAST is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by TRICAST in this report and the ***Specific Findings Report*** relate narrowly and specifically to the overall efficacy of MedImpact's policies, processes and systems relative to the State of Montana's paid claims during the audit period.

TRICAST, LLC

TABLE OF CONTENTS

INTRODUCTION

Audit Objectives

The objectives of the TRICAST audit of MedImpact's pharmacy benefit management were to determine if:

- MedImpact adhered to the contractual and pricing terms outlined in the agreement with the State of Montana;
- MedImpact accurately administered benefit provisions;
- MedImpact is compliant with all Health Insurance Portability and Accountability Act (HIPAA) policies and procedures;
- MedImpact is performing agreed upon Coordination of Benefit (COB) duties;
- MedImpact is meeting contractually approved Performance Guarantees; and
- Potential for fraud, waste and abuse against the pharmacy plan(s) was monitored and controlled by MedImpact.

Audit Scope

TRICAST's audit encompassed the contract in force and the pharmacy benefit claims administered by MedImpact for the audit period of January 1, 2014 through December 31, 2015. The State of Montana's population of claims and the total net plan paid (equals total payment less member copayment) during this period:

Total Number of Prescription Drug Claims Paid	964,277
Net Plan Paid	$79,083,923

The audit included the following seven components.

1. **Pricing and Fees Audit**
2. **Reconciliation of Pricing Guarantees**
3. **Benefit Payment Accuracy Review**
4. **HIPAA Compliance**
5. **Coordination of Benefits (COB)**
6. **Performance Guarantees**
7. **Fraud, Waste and Abuse (FWA)**

Key findings for each component can be found in the following sections of this report.

PRICING AND FEES AUDIT

PRICING AND FEES AUDIT

Pricing and Fees Audit Objective

The Pricing and Fees Audit verified that claims were processed according to the discounts and fees specified in MedImpact's contract with Montana Association of Health Care Purchasers (MAHCP).

Pricing and Fees Audit Scope

After a thorough forensic verification of the electronic claim data provided by MedImpact, TRICAST systematically re-priced 100% of prescription drug claims paid during the audit period to determine:

- Discounts were applied correctly based on the lessor of Maximum Allowable Cost (MAC), Average Wholesale Price (AWP) and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Pricing and Fees Audit Methodology

Contract Document Review

TRICAST requested and received from the State of Montana and MedImpact all contracts, amendments, formulary drug lists and reconciliation documents.

Claim Validation

We mapped and validated the raw claim data provided by MedImpact to TRICAST's standard layout. Raw claim data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of MedImpact's processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred as TRICAST's data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The data forensics included comparing the mapped data to the following benchmarks:

- Prior authorizations
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

To complete the claim validation we conducted a conference call with MedImpact to verify that:

- Pharmacy benefit claims data provided for this audit was complete and accurate;
- Claims were loaded correctly into the TRICAST system; and
- Claim counts and total paid claim amounts were accurate.

Pricing and Fees Analysis

Drug discount rates are calculated based on the AWP and evaluated by brand and generic then applied to the delivery channels of mail, retail and specialty pharmacy claims. The discount portion of the pricing audit compares the contractually agreed upon discount rates to the discount rates that were actually achieved.

The State of Montana does not contract directly with MedImpact for PBM services. Along with other major Montana employers, both public and private, the State participates in a contract with the Montana Association of Health Care Purchasers (MAHCP) to access pharmacy benefits and services. The contract between MAHCP and MedImpact provides for a number of different services and incentives, some of which are determined collectively for all members of the purchasing coalition with others being specific to the State.

MAHCP has contracted with AmeriPharm for the mail order discounts and dispensing fee rates. MedImpact then codes those rates in their system for appropriate adjudication however MedImpact will not complete any reconciliation on mail claims. Any discount guarantees for mail will need to be reconciled with AmeriPharm and MAHCP. The overall discount guarantee is at the MAHCP level.

Pricing and Fees Audit Findings

Pricing Findings

All adjudication methods for determining the correct allowance for prescriptions drugs by type and distribution method were applied by MedImpact during the audit period. TRICAST only found an under-performance in pricing for mail claims. MedImpact does not hold the mail order contract with MAHCP; therefore they don't reconcile mail claims. As a result, TRICAST cannot complete any further reconciliation on mail claims.

Dispensing Fee Analysis

The dispensing fee was the defined amount contractually agreed upon by MAHCP and MedImpact as the amount to be paid by the plan to the pharmacy for dispensing a prescription.

As shown in the following table, TRICAST's analysis identified fees that were under paid by MedImpact by $638,045 for the audit period. This represents a reduced liability to the State of Montana prescription drug plan.

Key	Over Payment *> Greater Than Contracted Rates*	Acceptable Performance *— Same as Contracted Rates*	Under Payment *< Less Than Contracted Rates*

Dispensing Fees (1/1/2014 – 12/31/2015)						
Component Description	**Contracted Dispensing Rate**	**Number of Claims**	**Total Contract Dispensing Fee**	**Total Actual Dispensing Fee**	**Variance**	
Mail	$13.45	94,266	$1,267,878	$754,666	$513,212	<
Retail Generic	$1.70	765,214	$1,300,864	$1,190,282	$110,582	<
Retail Brand	$1.70	98,037	$166,663	$152,412	$14,251	<
Total*		**957,517**	**$2,735,405**	**$2,097,360**	**$638,045**	**<**

** Specialty and subscriber or manual claims were not specified or were excluded from contract guarantees and are not included in these totals; however, TRICAST reviewed claims for reasonableness and found no outliers.*

RECONCILIATION OF PRICING GUARANTEES

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantee Objective

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in the MAHCP contract with the State of Montana were met and, if not met, that accurate credit or payment was made to MAHCP within the time frame specified in the contract.

Reconciliation of Pricing Guarantee Scope

Using the terms of the MAHCP contract with MedImpact, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other discount guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources
- MAC allowance for generic
- Specialty drug allowance
- Dispensing fees

Reconciliation of Pricing Guarantee Methodology

TRICAST used its proprietary AccuCAST® system to electronically compile total discount savings by silo (drug type and distribution method) and compare them to the contract guarantees in the MAHCP contract. If MedImpact's performance fell short of any of the guarantees, we validated that MedImpact recognized the shortfall and credited or paid the difference to MAHCP in a timely manner.

Reconciliation of Pricing Guarantee Findings

The following table demonstrates our findings relative to pricing guarantees.

Key	Over Performance *> Greater Than Contracted Rates*	Acceptable Performance *— Same as Contracted Rates*	Under-Performance *< Less Than Contracted Rates*

Discount Rates (1/1/2014 – 12/31/2015)								
Component Description	**Claim Count**	**Contracted Discount Rate**	**Actual Discount Rate**	**Contracted Claim Ingredient Cost**	**Actual Claims Ingredient Cost**	**Variance**		**Variance Percent**
Pharmacy Input Exceptions	310	0%	0%	$15,738	$15,738	$0	—	0.00%
Compounds	2,593	0%	0%	$328,921	$328,921	$0	—	0.00%
Implied Compounds	8	0%	0%	$286	$286	$0	—	0.00%
Specialty	5,623	14.97%	17.64%	$22,898,085	$22,178,725	$719,360	>	0.87%
Retail Brand Jan-June 2014	27,737	15%	18.93%	$6,470,317	$6,171,022	$299,295	>	0.36%
Retail Generic Jan-June 2014	186,954	77%	78.11%	$3,755,665	$3,573,670	$181,995	>	0.22%
Retail Brand July 14-June 15	54,133	15%	18.68%	$12,892,078	$12,333,776	$558,302	>	0.68%
Retail Generic July 14-June 15	379,766	77.25%	79.2%	$7,990,762	$7,306,230	$684,532	>	0.83%
Retail Brand July 15-Dec 15	26,082	15%	18.38%	$6,589,804	$6,327,562	$262,242	>	0.32%
Retail Generic July 15-Dec 15	185,823	77.5%	80.33%	$4,087,182	$3,573,018	$514,164	>	0.62%
Mail Brand	15,822	23%	26%	$10,546,757	$10,136,369	$410,388	>	0.5%
Mail Generic	78,302	90%	89.15%	$2,201,360	$2,388,721	($187,361)	<	(0.23%)
Total				**$77,776,955**	**$74,334,038**	**$3,442,917**	**>**	**4.17%**

** Pharmacy Input Exceptions, Compounds, Implied compounds and claims not falling into these categories were excluded from contract guarantees and are not included in these totals; however, TRICAST reviewed claims for reasonableness and found no outliers.*

TRICAST audited the time period of January 1, 2014 through December 31, 2015. TRICAST's results were then compared to the 2014 MTN01 and 2015 MTN01 reconciliation reports. TRICAST was able to validate the number of claims and overall discount rates achieved for each component.

In summary, MedImpact met or exceeded their contractual obligations outlined in the MAHCP contract. AmeriPharm under-performed in the mail generic pricing guarantee category. TRICAST recommends that the State of Montana work with MAHCP to ensure no money is owed for missed mail guarantees since the contract is measured and reported at the MAHCP level.

BENEFIT PAYMENT ACCURACY REVIEW

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Objective

The objective of the Benefit Payment Accuracy Review was to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

Benefit Payment Accuracy Review Scope

TRICAST created an exact model of the benefit plan parameters of the State of Montana's pharmacy plan(s) in AccuCAST and systematically re-adjudicated 100% of paid prescription drugs. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified but could not be explained by TRICAST's benefit analysts were provided to MedImpact for explanation. If adequate documentation was provided to support that the exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Benefit Payment Accuracy Review Methodology

After receiving the plan documentation from the State of Montana and MedImpact including, copayment and coverage rules, summary plan description(s) and/or plan document(s), TRICAST programmed the State of Montana's plan design in AccuCAST. Each claim was re-adjudicated and exceptions were identified. The exceptions were aggregated by category and analyzed by our benefit analysts. Exceptions that could not be explained were submitted to MedImpact for review.

TRICAST provided a sampling of 589 claims to MedImpact for review and response. Our audit results were based upon those responses.

Benefit Payment Accuracy Review Findings

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayments follow.

Copayment Plan Analysis (1/1/2014 – 12/31/2014)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percent**
487,285	$8,312,146	$8,024,568	$287,578	3.46%
Copayment Plan Analysis (1/1/2015 – 12/31/2015)				
Total Claims	**Copays per Plan**	**Copays Collected**	**Variance**	**Variance Percent**
476,992	$8,051,213	$7,925,750	$125,463	1.56%

TRICAST submitted 589 claims to MedImpact that represented potential exceptions to the copayment requirements. MedImpact reviewed the claims and provided TRICAST with the following explanations, "we believe the claim findings can be explained by one or more of the following reasons":

1. Claims with active Prior Authorizations
2. Claim in question is a COB claim
3. Patient prior authorization determined copay
4. Claims where members have satisfied out-of-pocket (OOP) amounts
5. Medication part of a Split Fill program

TRICAST's findings with MedImpact's responses below:

Retail and Mail Prescription Drugs			
Copayment Rule	**TRICAST Initial Findings**	**MedImpact Responses**	**TRICAST's Final Conclusion**
No Rule Matched	These are for mostly retail claims over a 30 day supply that didn't hit a rule because retail only allows a 30 day supply. We were not provided a list of drugs that would allow a 90 day supply at retail.	• MedImpact provided new drug lists	While the new drug lists provided to TRICAST didn't provide the evidence that these claims should have been allowed to pay over a 30 day supply, TRICAST reviewed the NDC's with the formulary and determined that claims paid appropriately as these were for items such as diabetic supplies, inhalers and syringes which come pre-packaged.
Specialty Tier S 150	These variances are for plan code MTN01S with a copay Tier of 7. There are 25 claims not filled at Diplomat charging a 25% copay. Remaining claims were filled at Diplomat but taking a variety of copays, 77 claims charging more than $150.	• COB edit • Patient PA determined copay	Based on MedImpact's responses, copays are paying correctly. There are, however, some member level PA's for specialty drugs that have end dates several years out which should be reviewed by the State.

Specialty Tier 8	These variances are for plan code MTN01S with a copay Tier of 8. We would expect a member to pay $250 copay unless members reached their OOP and 50 claims charged a $125 copay.	• Medication part of the Split Fill program to charge half the copay. • Patient PA determined copay • OOP Met • COB claim	Based on MedImpact's responses copays are paying correctly.
Retail Tier B, C, D, F	Majority of claims charged a $0 copay.	• COB claim • OOP Met • Patient PA determined copay	Based on MedImpact's responses copays are paying correctly.
Mail Tier B and C	Majority of claims charged a $0 copay.	• COB claim • OOP Met • Patient PA determined copay	Based on MedImpact's responses copays are paying correctly.

TRICAST was provided with two different sets of drug lists from MedImpact during this audit which were used as outlined in the plan design documents. During phone conversations with MedImpact, TRICAST was informed that the State of Montana has several one-off copay breaks for members that MedImpact is unable to systematically recreate in order for TRICAST to identify these claims across the entire claim set. While TRICAST was able to validate the copays based on MedImpact's responses, we were not provided the appropriate indicators within the claims data to identify COB claims and patient level prior authorizations. Without these appropriate fields provided in the data, TRICAST is unable to calculate out-of-pocket accumulators correctly.

Drug Exclusions/Prior Authorizations

Exclusions specify the drugs and products that a plan did not or would not cover unless there was a Prior Authorization (PA). Based on documentation provided by MedImpact, TRICAST created an exclusion drug list and PA drug list and then re-adjudicated the claims for these non-covered and prior authorized medications.

MedImpact provided TRICAST with updated drug lists after the first observations were provided. TRICAST sent the new variances to MedImpact in which they responded, "we believe that 'member restrictions' that have been approved by the State are the reason for the vast majority of these Exclusion and PA findings. Unfortunately, these member restrictions are not indicated within the claims detail file or any benefit level drug lists that were provided." In addition, MedImpact had the following responses:

1. In reviewing the PA Drug Coverage Exceptions, all of the PA required – except Pegasys, Pegasys Proclick, Simvastatin, and Vytorin – are for copay exceptions; this means that the member can obtain these medications at 100% member cost share without PA but will require PA approval for a lower cost share.

2. Review of the Simvastatin and Vytorin claims show that all of these were approved without PA because the member was grandfathered on therapy (i.e., PA not required if member has previously filled the medication).

3. Reviewing a sample of Pegasys and Pegasys Proclick claims, we find that there are member PA approvals on file.

TRICAST accepts MedImpact's responses for the claims requiring a PA if the State agrees members are allowed to receive these claims without a PA.

MedImpact provided claim level responses for all of the claims that should have been excluded according to plan design documentation. MedImpact indicated that claims paid correctly because either there was a member level PA in place, the drug was no longer excluded or it was covered as an over-the-counter (OTC). Based on MedImpact's responses TRICAST agrees claims are adjudicating appropriately.

Administration of Age Rules

Age rules specify that a participant must be within a specific age group for a specific medication to be covered.

TRICAST noted two categories of claims where members over the age of 17 and 50 required a PA, respectively. However, no PA is on the claim files. TRICAST provided MedImpact with 24 samples claims for review and response.

MedImpact indicated that Zostavax is covered per affordable care act (ACA) after the age of 50, and no PA is required. MedImpact also indicated that the claims for members 17 and over do not require a PA. The chart that MedImpact provided identified what ages a member didn't need a PA for. Members under the age of 17 require a PA.

TRICAST reran our analysis based on the new information provided and all claims are adjudicating appropriately.

Administration of Quantity Limits

The quantity limit is the maximum quantity that can be dispensed over a given period of time. Examples would include inhalers, injectables and patches.

TRICAST's quantity limit analysis examines the State of Montana's plan design and dosage rules, compares these to the pharmacy claims and identifies any discrepancies or trends. TRICAST identified claims with potential higher quantities per day or over a time period than was outlined in the plan documents. All of these claims were provided to MedImpact for review and response.

MedImpact indicated that all claims paid appropriately as there was a member level PA on file for all claims. The effect of the PA is to override the quantity limits otherwise imposed. Based on MedImpact's responses, TRICAST agrees claims are adjudicating correctly.

HIPAA COMPLIANCE

HIPAA COMPLIANCE

HIPAA Compliance Objective

The objective of the HIPAA Compliance Audit is to validate that Health Insurance Portability and Accountability Act (HIPAA) rules and regulations are properly established and being enforced to maintain Protected Health Information (PHI).

HIPAA Compliance Scope

TRICAST evaluated MedImpact's policies and procedures to validate HIPAA rules and regulations are properly established and being enforced to maintain PHI.

HIPAA Review Findings

TRICAST reviewed MedImpact's policies and procedures and found they demonstrate comprehensive control procedures, employee awareness and business protocols to maintain PHI in compliance with the HIPAA standard. MedImpact has implemented and is exercising best HIPAA practices.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

Coordination of Benefits Objective

The objective of the Coordination of Benefits Audit is to validate that MedImpact is performing agreed-upon Coordination of Benefits (COB) duties.

Coordination of Benefits Scope

TRICAST analyzed prescription claims adjudicated with COB coverage and validated that MedImpact is performing COB on behalf of the State of Montana.

Coordination of Benefits Findings

The analysis of State of Montana's COB claims revealed MedImpact is performing claim subrogation and coordination when a COB indicator is included in the claim file.

PERFORMANCE GUARANTEES

PERFORMANCE GUARANTEES

Performance Guarantee Objective

The objective of the Performance Guarantee Audit is to validate that MedImpact is meeting contractually agreed-upon Performance Guarantees.

Performance Guarantee Scope

TRICAST reviewed the Performance Guarantees included in the Coalition Pharmacy Benefit Administrative Services Agreement, effective May 12, 2009, between the Montana Association of Health Care Purchasers (MAHCP) and MedImpact. TRICAST requested reports from MedImpact to substantiate their performance levels for each of the measures in the Performance Agreement to determine if MedImpact had performed at the minimum level required to avoid paying a penalty to the State of Montana.

Performance Guarantee Findings

Of the 39 total performance guarantees listed in the Service Agreement, 16 are measurable at the client, or individual group level (State of Montana - MTN01) while 23 are measured at the MAHCP level to which TRICAST has no access.

State of Montana MTN01 Level:

- 2014 and 2015: All 16 of the client or individual group level performance guarantees applicable to the State of Montana were met.

FRAUD, WASTE AND ABUSE (FWA) REVIEW

FRAUD, WASTE AND ABUSE (FWA) REVIEW

FWA Review Objective

The Fraud, Waste and Abuse (FWA) Report identifies participants we believe should be considered for review because they meet three or more of the six TRICAST-established investigatory criteria as shown in the FWA Review Methodology chart.

FWA Review Scope

Review 100% of prescription drug claims paid during the audit period to assess if there were any fraud, waste and abuse from participants, pharmacies and/or medical providers.

FWA Review Methodology

TRICAST reviewed claims to identify utilization trends and determine if any anomalies exist.

Criteria	Description	What Does It Do?
1	Controlled Substances: Usage of 10 prescriptions in any 10 week period. **[Narcotic Usage]**	Helps identify potential abuse situations by providing high utilization criteria with potential doctor shopping.
2	Controlled Substances: Prescribed by four or more physicians. **[Narcotic Activity]**	
3	High Cost Prescriptions: Greater than $2,500. **[Excessive Cost]**	Helps identify excess cost.
4	Early Refill of Prescriptions: Criteria for retail claims is less than 60% being used and mail order is less than 50% being used when a subsequent prescription dispensed. **[Refill Too Soon]**	Help identify areas that provide oversight of the processing criteria delegated to the contracted MedImpact vendor.
5	DUR Therapeutic Overlaps: Utilizes the same criteria as identified for early refill but applied to prescriptions at different pharmacy providers, essentially exact duplication. **[DUR]**	Help identify areas that provide oversight of the processing criteria delegated to the contracted MedImpact vendor.
6	Dose/Refill Noncompliance: Reporting that compares the dosage on the prescription to the manufacturer identified benchmark dosage for the age demographic as reported in MediSpan. It also identifies gaps in therapy when compared to manufacturer benchmarks. The criteria used in this instance were to identify patients exceeding the manufacturer recommended dose by greater than 100% or double the benchmark and had a gap in therapy of greater than 50%. An occurrence such as this would indicate potential copayment avoidance. **[Dose Non-Compliance]**	Help identify areas that provide oversight of the processing criteria delegated to the contracted MedImpact vendor.

FWA Review Findings

TRICAST identified only five individuals with claims that had the potential of fraud, waste or abuse. When compared to other TRICAST clients of similar size, the number of cases and dollar amount involved were statistically insignificant.

FWA Review Recommendations

MedImpact has reviewed all five members recommended by TRICAST and has sent these members to case management for further review and research.

APPENDIX

MEDIMPACT'S RESPONSE TO DRAFT REPORT

MedImpact's response to the draft report can be found on the following page.

August 2, 2016

Re: #16007 State of Montana PBM Oversight Audit, Audit Report responses

Auditor Request:

Provide final responses to the Audit Report and the exceptions/issues identified by the auditor in this audit.

MedImpact Response:

Benefit Payment Accuracy Review

Copayments
Member Restrictions used to adjust copayment levels are determined solely by the State of Montana and are not driven off of any specific drug list – each Member override request is considered on an individual basis. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

Drug Exclusions/Prior Authorization
All drugs in the spreadsheet labeled "Exclusion and PA summaries, MI responses, vFINAL.xlsx" had a valid reason for coverage. Refer to that spreadsheet for detail.

Age Rules
Age edits for Zoster Vaccine, Foradil, and Serevent are coded to allowed coverage if the Member meets the age edit. A Prior Authorization is only required if members are under the age of 50 and 17 years for Zoster Vaccine and Foradil/Serevent, respectively. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

Quantity Limits
Quantity Limits were overridden by Plan exception. As such, these claims were paid correctly. Refer to the "2014_2015 Plan Design observations, MI responses vFINAL.xlsx" spreadsheet for detail.

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